December 6, 2018

The Honorable Mark Levine
Chair, Health Committee
New York City Council
250 Broadway, Room 1816
New York, NY 10007

Dear Chair Levine:

On behalf of Mayor de Blasio, thank you for the opportunity to submit comments in support of the New York Health Act.

In order to have thriving, healthy communities, every person must have access to health care. Lack of health insurance impedes one's ability to get the critical health care services they may need, and the uninsured tend to bear a higher financial burden from medical bills and suffer from worse health outcomes. Studies have shown that being uninsured is associated with increased prevalence of disease and death. Not having insurance also increases health disparities across race, ethnicity and socioeconomic status. Health insurance plays a major role in access to primary care and preventive health screenings, allowing individuals to manage their mental health needs, substance use disorders and chronic health conditions like diabetes and cancer. Insurance coverage also facilitates access to contraceptives and prenatal care.

Health insurance coverage is also important for the City's economy and job markets, both by protecting individuals from unaffordable medical bills and by enabling health care providers, including hospitals, community health centers and nursing facilities to provide the care their patients need. Expanding access to health insurance coverage and implementing a single payer system would support New York City Health + Hospitals' mission to provide high quality health care services to all New Yorkers regardless of their ability to pay. New York City Health + Hospitals – the largest municipal health care system in the nation – is the safety net provider for over one million New Yorkers each year, and the largest provider of care to the uninsured in New York City.

The insurance reforms enacted by the Affordable Care Act, including the subsequent creation of the New York State of Health Marketplace in 2013, have significantly expanded health insurance coverage to millions of New Yorkers. Between 2013 and 2016, almost 16 million New York State residents gained coverage, and the uninsured rate among adults in New York City declined from 16.8 percent to 9.8 percent. New Yorkers have come to rely on the protections afforded by the Affordable Care Act such as preventive services like immunizations and cancer screenings, annual wellness visits and prescription drug coverage for Medicare recipients. Despite this progress, coverage gaps remain; over 1.1 million New York State residents, including 663,731 New York City residents (7.8%), remain uninsured.

A single-payer health system would provide coverage to these uninsured New Yorkers. The New York Health Act would create a comprehensive system of access to health insurance to provide a health plan available to every New York State resident. The program does not require its participants to pay any

premium or out-of-pocket costs and provides all benefits currently included in Medicaid, Medicare, Child Health Plus and other state programs. This new system will ensure access to critical care to those who need it most and increase positive health care outcomes for all New Yorkers.

A single payer system would also make major strides to decrease segregation of care based on insurance type and decrease needless administrative costs of our current health care system. Research has shown that many private practices do not accept Medicaid; other studies suggest that Medicaid is accepted at hospital clinics, but not necessarily in the faculty practices of the same hospitals. The difference in rates paid by Medicaid when compared to private insurance is a contributor to this inequity, which would be addressed with a single payer system. In addition, health insurance companies and health care providers – including New York City Health + Hospitals – spend far too much time and money in the administrative processes of billing for, denying, appealing and collecting payment for health care services. A single payer system would allow health care providers to devote their time and money to caring for the needs of their patients.

The removal of the Affordable Care Act individual mandate penalty, the pending lawsuit filed by Texas to strike down the Affordable Care Act and the chilling effect of the recently proposed "public charge" rule create significant uncertainty as to whether New York City can sustain its recent gains in health insurance coverage. A recent study found that the number of uninsured children in the United States increased in 2017, for the first time in nearly a decade, and projected that the decline in coverage would likely continue if the proposed public charge rule goes into effect. As the Trump Administration continues its assault on the Affordable Care Act and Medicaid, it is our job to ensure that everyone, regardless of their age, employment status, household income, immigration status or health status, has access to health care. The New York Health Act would support this access for every New York State resident.

The City of New York supports the New York Health Act and we call upon the State Legislature and Governor to pass a single-payer health system in New York State.

Thank you for the opportunity to join the growing chorus of voices in support of a single-payer health system.

Sincerely,

Oxiris Barbot, MD
Acting Commissioner
Department of Health and Mental Hygiene

Mitchell Katz, MD
President and Chief Executive Officer
NYC Health + Hospitals

NYHA Testimony
Grace McCreight
420 E. 21st Street, #308
Brooklyn, NY 11226

I'm writing in support of the New York Health Act because recent experience has taught me that anyone can fall through the cracks in our broken healthcare system.

In September, I started a new job. After a year of searching, I landed a position doing exciting work in a field that interested me. It felt like my professional life was moving forward, but I also saw signs that my health was regressing. Painful, unexplained bruises appeared on my skin, along with clusters of red dots called petechiae, which are caused by ruptured blood vessels. These are symptoms of a chronic bleeding disorder called ITP, with which I was diagnosed as a teenager. With ITP, the body attacks its own platelets - the cells that clot your blood. This means that cuts and injuries don't clot, and can lead to heavy blood loss. Extremely low platelet counts can even put me in danger of internal hemorrhage.

My condition had been stable for a decade, so it was very frightening to see the bruises reappear. But I had to consider the cost before I could even think about seeing the doctor. As a teenager, my treatments were covered by my parents' insurance. Once, I saw a bill on the kitchen table. A single IV treatment was billed for thousands of dollars, before insurance adjustment. My current insurance - from my new job - didn't kick into until 30 days after my start date. Without coverage, there's no way I could pay for treatments, let alone all the doctor's visits and blood tests along the way.

My choice was falling into deep debt, or hoping and waiting. So I waited. For two weeks, I watched the bruises grow. I stopped shaving to avoid the chance of cuts. Even the pressure of holding my purse would cause wide strips of petechiae. By the time I saw a hematologist - on the first day that my insurance was valid - my platelet count was 12. The lowest healthy count is 150.

After dozens of blood tests and weekly IV treatments, my condition is stabilizing. But I know that I was very lucky. During those two weeks, any kind of injury could have caused serious bleeding and put me in the ER.

I shouldn't have to choose between my health and my finances, but I know that this is a choice New Yorkers make every day. It's shameful that people have to debate whether or not they can afford good health. Relying on employers for insurance puts people in danger when they're between jobs or without stable employment.

With the NYHA, we can fix this. We can ensure that all New Yorkers get the care they need. As our elected officials, you have the chance - and the responsibility - to fix a system that harms all of us.

The Business Council

Testimony to

New York City Council Committee on Health

Res 0470-2018

Submitted by
Lev Ginsburg, Esq.
Director of Government Affairs

December 6, 2018

On behalf of The Business Council of New York State, Inc. and our more than 2,300 members – businesses large and small all across the state – I wish to submit these comments into the record as part of this committee's hearing on a resolution in support of the New York Health Act. As the state's largest statewide employer advocacy organization, we often address issues impacting the state's economic competitiveness, including business costs driven by state policy actions. The establishment of a government-run healthcare system in New York would undoubtedly impact every employer and have a deleterious effect on the economy of the state as a whole.

In light of the barrage of rhetoric supporting such a government-run system, it's useful to separate myth from fact. Government-run health insurance is not synonymous with universal coverage. We know this because New York has nearly achieved universal coverage under the current health insurance structure. As of today, over 95 percent of New Yorkers have health care coverage. Of the remaining 4.5 percent, roughly half are eligible to receive coverage under existing plans and choose not to. The New York Health Act is a dangerous solution to a problem the does not truly exist.

Furthermore, the current bill, which this committee is voting to support, would be frighteningly expensive. Since neither the bill nor its sponsors have ever addressed the actual costs, multiple outside studies have been used to estimate them. The results are scary. Starting at just under $100 billion per year, and climbing all the way to a quarter of a trillion dollars, the cost is far more than the entirety of our current state budget, necessitating tax increases larger than any in history. Other studies point to a potential loss of 150,000 jobs in the state. Thankfully, polls show that despite the rhetoric, there is not some great groundswell of public opinion pushing for these changes.

The fact is that other states have already tried this and failed under the enormity of the financial impact. Lawmakers in California proposed and ultimately rejected a similar plan when its true costs were revealed. Similar stories played out in Vermont and Colorado. Government-run healthcare advocates often point to universal coverage plans and mandates that exist in other countries as something worth emulating here. In fact, the majority of countries that offer universal coverage do so with a mix of private and public insurance; the exact same as our current system. But the proposed plan is far more extreme, outlawing private insurance all together.

Single payer systems throughout the world tend to have greater social inequalities in accessing care, based on wealth and other factors, than does the US. This will be exacerbated in underserved urban neighborhoods and rural areas under a New York single payer scheme, as falling reimbursement rates to hospitals will force poorer medical centers to shut their doors.

There are certainly problems with our current system and improvements to make. They can be done without reinventing the wheel and guaranteeing economic turmoil. Improving our current system and reaching total coverage is a goal everyone can and should get behind. Decimating our economy with massive tax increases and job losses while putting access to our health system in the hands of bureaucrats through government-run healthcare is simply the worst way to approach it.

I appreciate the opportunity to share my thoughts on this important issue and on behalf of The Business Council and our members, I thank the committee and urge it to vote no on Resolution 0470-2018 calling on the State Legislature to pass and the Governor to sign A.4738-A/S.4840-A, legislation that would establish the New York Health program, a universal single payer health plan for all New York State residents.

Kamini Doobay, MD, MS
NYC Coalition to Dismantle Racism in the Health System

With our stethoscope and white coat, we promise to do no harm,

We must find the voice within us to break silence and sound the alarm,

Not doing is doing when we see injustice and turn away,

That's why we are here to #ProtectOurPatients Today.

Our current healthcare financing system places profit over patients and perpetuates the cycle of injustice and oppression. The multi-tiered, maldistributed insurance system in New York State results in racial inequities. The first step to addressing racial inequities and improving outcomes for people of color is guaranteeing the human right to healthcare. This is not idealistic, it is realistic. Everyone deserves healthcare.

As an emergency medicine resident, I rotated on the orthopedic surgery service. While working in the orthopedic fracture clinic, I encountered a patient. This man happened to be a physics professor in another country. He came to this country, met his wife, and started a family. While walking just a couple of blocks from the bus stop to his job, he was hit by a car. An ambulance transported him from the scene of the accident to a well known academic non-profit hospital in New York City. There, he was told that he had fractured his tibia (one of the bones in his leg). He was splinted and told to return to the hospital in 2 weeks for further care and management. When he returned to the clinic, he was informed that because he had public insurance he would have to find a hospital that took his insurance and that the orthopedic surgeon could not see him. Never was he called or given a single pamphlet that could direct him to which hospital he could seek or receive care.

He made calls, and eventually found himself in the clinic of a public hospital 3 months after the incident. This man's leg was in a splint for 3 months. By the time I saw him, he had a pressure ulcer and discoloration of his leg. He apologized to me and blamed himself. Tears fell down his face, and I could not help but cry with him. Our healthcare system failed him.

While working a shift in the pediatric emergency room, I saw a teenaged girl who came in with vaginal bleeding and severe abdominal pain. I explained to the girl and her father that we need to do an ultrasound right away as her symptoms could indicate a life threatening diagnosis. As I stepped away to put in orders, my patient's father followed me. When we were far enough from his daughter, he said to me, "Doctor, please make sure she is safe. But, I need you to know that I currently do not have insurance. Can we only do the tests that are absolutely necessary?"

In his face, I saw a father that would do anything to eliminate his daughter's suffering. I later learned that my patient's mother was not present in her life. Her father raised her and the two of them were incredibly close. He worked in construction to provide for her. However, he had recently gotten laid off and with his job, he lost his insurance.

I wanted to say to this man, “Don’t worry. Your insurance status does not matter.” It may not have mattered to me, a doctor who was invested in saving his daughter’s life and who wanted to do everything possible to do so. But, it did and should matter to him as he would receive thousands of dollars of hospital bills after this one visit to the ED.

When our patients stay at home - suffering or even dying - because they cannot afford to come to our doors, we fail them.

It is also not a rare experience for a patient to demand an MRI, a specialist consult, or more laboratory tests because of his/her insurance status. I’ve heard various forms of the statement, “My insurance is the best so I deserve more.” This over-testing, not surprisingly, does not result in better outcomes.

These are just a couple of my experiences that highlight the urgent need for a single payer system in New York and beyond. As healthcare workers, we believe in health care systems that value all patients by providing equitable access to care. When our hospitals and clinics turn away patients because they are uninsured or underinsured - which are disproportionately people of color and poor people - we are deciding that their lives and their health are less valuable.

testimony in support for res. 470

Sarina Prabasi and Elias Gurmu own Buunni Coffee, an independent coffee business in New York.

We are the owners of Buunni Coffee, a small and growing business in New York City. Buunni has locations Manhattan and the Bronx. We are strong supporters of the New York Health Act because it would transform our business, and the well-being of our staff and family.

Under the current health system, we cannot afford to provide healthcare to our staff, though it is our deep desire to do so. The costs of premiums for ourselves and for our staff would be more than our total net profit by orders of magnitude. We are truly a 'mom and pop' shop, and one of us has a chronic illness. One of us is employed full-time and our family has healthcare coverage through the employer's plan. Health coverage is a major reason for continuing to work full-time while trying to grow our business too. If New York would pass the NY Health Act, there is no doubt we would be able to grow our business and employ more people.

Staff sickness is a major risk to our business, and we are worried about the well-being of our staff. In addition, once we train our staff and they develop skills with us, they understandably want to work for a company that can provide them with health benefits. So, as a small business it is very difficult to retain our most valuable staff.

If both of us were to work full-time on our business, we could grow it significantly, but with two small children, and a complicated health history, we must prioritize quality healthcare and therefore split our time and slow down our business growth.

We believe in the NY Health Act for moral, practical and business reasons, and hope that the NY City Council will hear the voices of New Yorkers who are working so hard, and yet don't have the peace of mind of knowing they can get quality healthcare when they need it.

Thank you.

Testimony in favor of Resolution 470/The New York Health Act

To whom it may concern,

There is a lot of conversation about getting people insured, but being insured ensures you of very little. I make a good living but I work part time and through free lance jobs as a teacher and actor. And since I have no single full time employer, I get benefits from nowhere. I buy insurance from the NY Health Exchange. In 2018, my premiums were $509/month with a $2,000 deductible. That's over $8,000 for the year BEFORE ANYTHING IS COVERED. That's about 12% of my income so that I'm eligible to pay co-pays to see a doctor. Simply untenable. And it's going up - about $600/month on the same plan for 2019.

Because of these expenses, I've had to cancel my insurance for the last two months of 2018 because I can't afford to buy an engagement ring for my girlfriend. Not so dramatic, I'm not saying those who oppose the NY Health Act don't want me to get married. It's just normal. This should not be normal. We don't buy insurance in case we need the police. We don't have to get a cheaper-high deductible plan to cover us in case our kids want to go to school. We have public police forces and public schools because these are necessary in order to create a fair economy and just society. Thank you,

Rich Hollman

NYC Council Hearing on the New York Health Act

Testimony by Sandra J. Stein

Honorable Council Members:

I am the mother of a nine-year-old boy who desperately needs New York State to pass the New York Health Act.

On August 16th of 2011, my perfectly healthy and typically developing almost-three-year-old son woke up having a seizure. We went by ambulance to the Morgan Stanley Children's Hospital at New York Presbyterian, about 20 blocks from our Washington Heights apartment. After a dose of IV Ativan the seizing stopped and when he awoke from the medication, he went back to his walking and talking self within a couple of hours. We were sent home with a referral for a neurologist. The next day, my son and I were reading a book together when he said, "Mommy, my foot is flying" as his right foot jumped in tiny kicking motions. "You're not doing that?" I asked. "No Mommy, my foot is flying by itself."

Back to the hospital we went, where he was admitted, and where over the next several days we watched him lose his ability to walk, talk, swallow, focus his eyes, and reliably breathe. It was like watching him disappear into his body, now either slumped, listless, and comatose, or storming, thrashing, screaming and biting through his lips. He was eventually diagnosed with a newly classified disease called anti-NMDA receptor encephalitis, in which the body produces an antibody that breaks the blood-brain barrier and attacks the NMDA receptors in the brain. Within a very short time, my son went from perfectly healthy to catastrophically ill. While living in the pediatric ICU, my son was regularly resuscitated when his heart or lungs would unpredictably stop. He underwent multiple surgeries: a tracheostomy, gastrostomy tube placement, pacemaker placement, and several other life-saving procedures.

Before my son lost his ability to speak, he was a funny and deep-thinking toddler who had two favorite questions to ask from the time his language abilities blossomed: **"What are you thankful for?"** and **"What's the purpose?"** both of which he repeated frequently. To sustain myself through the terror of his disease, I continued to ask myself the questions he most loved to ask me.

What was I thankful for? I was thankful for my son's apparent will to live, the decent prognosis he had for survival, and the multiple machines, surgeries, and medications that kept him alive during the worst of his disease.

What was the purpose: To support him through the life-threatening phase of his disease so he could move onto what promised to be a lengthy recovery.

About two months into the hospitalization I started receiving calls from the billing office at Columbia Doctors, the Columbia University Medical Center's hiring agency for all practicing doctors at this hospital, to ask why I kept choosing out-of-network providers. I

was informed that while the hospital had a contract with our insurance, the doctors did not. In truth, I did not have a single choice of doctor while my son was in-patient and seen by whomever happened to be on service on any given day. And due to his medical complexity and severity, he was seen by multiple services every day.

I was told that I had been sent to collections for non-payment of bills that I didn't even know I had as I held bedside vigil for my son while he teetered for months on the border of life and death. I was told he was eligible for institutional Medicaid, but the Medicaid office at the hospital and the social workers on the floor claimed there was no way to enroll him without me leaving his bedside to go to the midtown offices and wait in line. I refused to leave my son's bedside while he was in such a critical state; it was impossible for me to focus on anything besides his moment-to-moment survival.

After 15 months between three hospitals with different insurance contracts causing more billing and payment complications, we were discharged to provide hospital-level care at home, through New York State's Care at Home 1 Medicaid waiver program. We converted our small uptown apartment into a mini-medical facility with oxygen tanks, feeding pumps, durable medical equipment, medication and supply inventories, and round-the-clock staff. I spent months untangling the medical billing, collections attorney demands, and Medicaid snafus, ultimately asking for an audit of our entire account with Columbia Doctors, all while caring for my now non-verbal, non-ambulatory, tube-fed, near-catatonic, medically complex child at home. We have had multiple hospitalizations since that time and through the luck of an out-of-network benefit and Medicaid have managed all of the bills for Columbia Doctors at New York Presbyterian who have continued to care from him over years. I return to my son's questions:

What was I thankful for? I was thankful for the out-of-network benefit tucked into the fine-print of our insurance policy, the woman at the Columbia Doctors billing office who was assigned to work with me to clear up the incredible billing mess, and his retroactive eligibility for NY State institutional Medicaid.

What was the purpose?: To keep my son alive and avoid bankruptcy for what turned out to be multiple-millions of dollars of doctor and hospital bills. The financial consequences of his disease have been considerable and ongoing, causing us to lose income, property, and the financial security we once had.

The fight to get everything we need to keep our son alive has been daily and draining. We can only work with the preferred providers who have contracts with our insurance company, an ever-evolving list that changes with contracts negotiations. Each time the insurance company discontinues contracts with providers, we are required to scramble to find new ones and to restart complicated processes of doctors' orders, prior authorizations, and insurance approvals. Then, we start to work with a new set of highly dysfunctional providers to fill and deliver the correct orders of life-sustaining medical equipment, staffing, and supplies. I have become expert in these systems, where and how they fail both in the hospital and in care-at-home, and, with more time, I could identify for all of you the profit-motivated cause of each and every dysfunction.

My son uses his insurance daily, in his need for overnight nursing to monitor for seizures, prevent aspiration, and to vent his g-tube and in the medications and medical supplies he uses every day. When my husband was changing jobs we could not figure out how to move our son from one policy to another without threatening his life. We

cannot have a single day of disruption of these critical services and changes in insurance often necessitate changes in providers.

We ended up using his Cobra benefit to keep him on the policy we had when he first got sick, and his eligibility for that expires within the upcoming calendar year. We are frankly not sure what is possible for ensuring access to his team of highly specialized doctors, his current group of nurses, his medications and supplies during this upcoming transition--when we need to enroll him in a new policy, with a new set of benefits that are often explained in the fine print of policy documents one can only access after enrolling.

Each time there is a change, the medical consequences of my son not getting what he needs render him potentially more expensive to the healthcare system, to the insurance company and to New York State, not to mention the unnecessary suffering he endures. If the replacement g-tube does not come on time, I need to take him to the hospital to get it replaced, a procedure I can easily do at home. If the wheelchair replacement or brake repair is delayed or he outgrows his ankle-foot orthotics, he risks bodily consequences that could ultimately require additional medical procedures. All the procedural delays make him not only suffer more, but also ultimately cost more to care for. I return to my son's questions.

What am I thankful for?: I'm thankful for my son's Cobra eligibility , which I would like to see extended indefinitely for people with disability determinations to avoid any discontinuity of care for those with medical complexity who require daily support until New York state adopts a single-payer approach.

What is the purpose?: To get my son what he needs without procedural disruptions created by the need to enroll in new policies due to a job switch, and to limit his vulnerability to any attempted discrimination against those with pre-existing conditions.

My son has fought hard to regain his prior functions. While still 100% dependent for all activities of daily life, while still needing a wheelchair, and still non-verbal, he has relearned to walk with the assistance of a gait-trainer, he no longer has a tracheostomy or pacemaker, he has developed a communication system using vocalizations, eye gaze, and his right hand, and, to my utter joy, he can now eat by mouth. He still cannot feed or dress himself, but he can signal which snack he prefers to eat or which shirt he prefers to wear. He goes to an amazing New York City public, neighborhood school and thrives in an inclusion class. While his ability to express himself is quite limited, his comprehension is fully intact. His teachers and classmates have watched his determination and progress in amazement. He deeply enriches the lives of all who know him.

One of the 11 surgeries he has endured was to place magnetically adjustable rods in his back to correct for his severe scoliosis, a neuromuscular consequence of his disease. The plan was to use these rods until he was old enough for a full spinal fusion. After a few years with the rods, we recently learned that one of them snapped, and we are now on the OR schedule for surgery number 12, a full spinal fusion, in early February of 2019, with the same orthopedic surgeon who placed the rods (and has done two other surgeries on my son) again at New York Presbyterian. My son will require an ICU stay after the surgery, and then several weeks of in-patient rehab at another facility.

Two weeks ago, on Wednesday, November 21st, the day before Thanksgiving, I received an email from New York Presbyterian hospital.

"*Dear Valued Patient,"* it read," *We are writing today with important information about negotiations we are having with your insurance company, Empire Blue Cross Blue Shield, which is owned by the Indianapolis-based, for-profit insurance company Anthem (Empire/Anthem). Our contract with Empire/Anthem expires at midnight on December 31, 2018, and we have been trying hard to work on a new contract that determines how the hospital and its affiliated physicians...are paid for the care you receive. So far, Empire/Anthem has stuck with its unreasonable demands and taken a hardline stance in our negotiations... If we are unable to reach an agreement on a new contract by December 31, all NY-Presbyterian facilities...will be considered out-of-network providers for all Empire/Anthem members as of January 1, 2019."*

I tried not to panic as I made multiple calls to figure out what was now possible for my son.

Back to his questions:
What am I thankful for?: I'm thankful for the many people on the other end of my frantic phone calls that Wednesday who tried to help me figure out what to do next. Everyone I spoke with, at the hospital, the NYC Healthline, and the insurance company were caught unaware by the institutions that employ them, yet tried in earnest to help me plan for this new potentiality, albeit with completely contradictory information, within and between entities.

What is the purpose?: Perhaps the purpose of that email was to generate political noise toward a better contract for New York Presbyterian or to provide us a month to scramble for alternative surgical plans should the contract negotiations truly fall through. My sole purpose is to have my son get the surgery he needs, by the same surgeon who has operated on him three other times (including placing the now-broken rod) and to continue my son's access to the hospital and doctors that have provided his critical and ongoing complex care for the past seven years.

After spending several hours of the days following Thanksgiving speaking with the insurance company, surgical schedulers, multiple doctors and administrators, after alerting my employer that the surgery (and my planned days off) might have to be moved up, and after learning that multiple families were affected in ways that the hospital operating room schedule could not accommodate before the contract was likely to expire, I received an email from the surgical scheduler: "The hospital and Empire were able to reach an agreement at 2am today. The hospital will remain in network with Empire." I breathed a heavy sigh of relief.

What I am describing here is maddening. It is grueling. It is senseless; it is organized for the profits of insurance companies, supply companies, equipment companies, nursing agencies, and all other medical cost-inflators, including wildly confusing and mysterious cost-setting practices at hospitals. There is absolutely no sense in my son changing doctors, nurses, suppliers, and hospitals due to contract negotiations between money-motivated entities, and each change creates potential for mistakes and disruptions to his care, ultimately making him more expensive to the system as a whole. I am in touch with multiple mothers around the world whose children of all ages have the same disease as my son, which can strike anyone at any age and at any time. I see the differences in the

medical approach and outcomes based on health policy between countries. These mothers tell me often how thankful they are NOT to live in the United States while their children are affected by this disease.

New York State has an opportunity to lead the way in healthcare in our country. While the current federal administration has introduced lethal healthcare policies and market deregulation over the past two years, I have been cautiously hopeful that any policy impact would be mitigated by NY State's commitment to such protections and regulations. I have also breathed a modest sigh of relief with the midterm election results and the current roster of Albany electeds.

What am I thankful for?: That we live in New York State with a fighting chance for single payer healthcare policies.

What is the purpose?: To ensure that every New Yorker has access to continuous, quality healthcare.

We have the tax base. We have the medical facilities. We have the popular demand. We have the brain power. We have the moral obligation. We have the 2018 Rand research demonstrating that New York State single-payer healthcare will either be financially net-neutral or net positive for New York State. Thus far, what we have not had is the political will to move bills out of committee and to test the rhetoric of those who support and the resolve and risk calculus of those who do not.

My son, my husband and I, along with so many others, are counting on our elected officials, both here and in Albany, to harness the political will and to finally pass the New York Health Act.

I want to return just one more time to the questions my son asked before losing his ability to speak.

What am I thankful for?: I'm profoundly thankful for the disability rights advocates, healthcare advocates, and elected officials who have worked tirelessly to get the New York Health Act this far.

What is the purpose?: To get New York State to take the lead on sensible, universal, single-payer healthcare in our country.

Please, I implore you, vote in favor of the New York Health Act on Resolution 470.

Thank you.

NY Health Act

Hi, I attended the hearing today on the NY Health Act but needed to leave at 3pm.

I am an International Board Certified Lactation Consultant (IBCLC) who does home visits to see new parents who need help breastfeeding. I want to make sure that under the NY Health Act, parents will be covered for lactation support if they need help to breastfeed their babies.

Breastfeeding has been shown to reduce risks of many negative health outcomes for both nursing parent and baby. However, some clients are not reimbursed by their short-sighted insurance company (including Medicaid plans) when they hire IBCLCs if they aren't also licensced MDs or RNs. (NY has a lactation consultant licensure bill in the Assembly.)

Thank you for supporting the health of New Yorkers!

Tova Ovits, IBCLC
FirstLatch.com

To: Speaker Corey Johnson, Chairman Mark, Levine, and Members of the New York City Council Health Committee

From: Mary Bassett, MD, MPH

Date: Thursday, December 6th, 2018

Re: Official testimony in support of Resolution 470 in favor of the New York Health Act

Good afternoon. My name is Mary Bassett. As a long-time resident of New York City and as a medical doctor and public health advocate, it is an honor to speak in support of the Resolution in support of the NY Health Act and for improved Medicare for All with a single payer health plan. For identification purposes, I stepped down as the City Health Commissioner two months ago and am presently the Director of the Center for Health and Human Rights at the Harvard School of Public Health, where I am a professor.

As you know, the United States spends more by far on health care than any other country. We comprise about 5 percent of the world population and account for about 50 percent of global health expenditure. And for this we get health outcomes that rank at or near the bottom of performance compared to other wealthy nations. If the goal of a health system is to deliver better health, the US system gets a "D". A single payer system addresses this unconscionably fragmented, costly and inefficient, for-profit private system by providing universal comprehensive coverage in a public health care delivery system.

But that is not all. Although our current system fails us all, the poor and communities of color suffer the most. People of color and immigrants bear the brunt of the failure of our current fragmented, privatized system. Single payer promotes equity and stands to benefit especially those who have been left out and left behind. If you see health as a human right, you should support the NY Health Act.

The NY Health Act would represent important progress, as it will:

1) Guarantee coverage for every resident regardless of income, employment, immigration status.

2) Eliminate financial barriers to care that in the current system keep people from seeking needed care, resulting in worse outcomes.

3) Ultimately improve health outcomes, including maternal and infant mortality indicators.

I want to take a moment to point out another benefit of a single payer system. On September 22, 2018, the Department of Homeland Security proposed a new regulation in the definition of "Public Charge", which is used to identify legal immigrants who may become dependent on the public purse. Long limited to cash assistance, the new regulations would extend to Medicaid, food stamps, housing and other benefits. These proposed measures already are having a chilling effect. For example, legal residents on a pathway to citizenship are afraid to enroll their citizen children in child health insurance or free vaccination programs. These dangerous changes to the "public charge" are opposed by a host of physician organizations. NYS could protect its immigrant residents by eliminating means-tested healthcare and guaranteeing it as a right to all residents.

We should oppose these changes to Public Charge and support the NY Health Act. Thank you.

RICHARD N. GOTTFRIED
75TH ASSEMBLY DISTRICT

CHAIR
COMMITTEE ON HEALTH

NEW YORK STATE ASSEMBLY

822 LEGISLATIVE OFFICE BUILDING, ALBANY, NY 12248
TEL: 518-455-4941 FAX: 518-455-5939

250 BROADWAY, RM. 2232, NEW YORK, NY 10007
TEL: 212-312-1492 FAX: 212-312-1494

E-MAIL: GottfriedR@nyassembly.gov

COMMITTEES:
RULES
HEALTH
HIGHER EDUCATION
MAJORITY STEERING

CHAIR
MANHATTAN DELEGATION

CONTACT: Mischa Sogut, 518-455-4941
SogutM@nyassembly.gov

THURSDAY, DECEMBER 6, 2016

Support the New York Health Act

Testimony of Assembly Member Richard N. Gottfried
Public Hearing: City Council Committee on Health
City Hall

I am Assembly Member Richard N. Gottfried. I chair the Assembly Health Committee and I am the introducer, along with Senator Gustavo Rivera, of the New York Health Act, to create single-payer health coverage for every New Yorker. I appreciate the Council Health Committee holding this hearing on Speaker Corey Johnson's resolution endorsing the bill. I support the resolution.

In both houses of the State Legislature, we now have solid majorities who have co-sponsored, voted for, or campaigned supporting the NY Health Act. And Governor Cuomo supports single-payer health coverage, although he says he has questions about whether it can be done at the state level.

Every New Yorker should have access to the health care they need, without financial obstacles or hardship. No one says they disagree with that. And the New York Health Act is the only proposal that can achieve that goal.

In NY State, we spend $300 billion – federal, state, and non-governmental – on health coverage. Nationally, we spend far more than any industrial democracy as a percentage of GDP. But 18 cents of the insurance premium dollar goes for insurance company bureaucracy and profit. Our doctors and hospitals spend twice what Canadian doctors and hospitals do on administrative costs, because they have to fight with insurance companies. We pay exorbitant prescription drug prices because no one has the bargaining leverage to negotiate effectively with drug companies.

Just about every New Yorker – patients, employees, employers, and taxpayers – is burdened by a combination of rising premiums, skyrocketing deductibles, co-pays, restrictive provider networks, out-of-network charges, coverage gaps, and unjustified denials of coverage. I know I am, and I bet everyone in this room is.

And those financial burdens are not based on ability to pay. The premium, the

deductibles – the insurance company doesn't care if you're a multi-millionaire CEO or a receptionist.

In a given year, a third of households with insurance has someone go without needed health care because they can't afford it – and usually for a serious condition.

The number one cause of personal bankruptcy is health care — even for those who have commercial health coverage.

We've put control of our health care in the hands of unaccountable insurance company bureaucrats. Nobody wants insurance company bureaucrats deciding what doctor you or your family can see and when.

The health insurance system means massive cost increases for most everyone and better health care for hardly anyone. It's a disaster.

But it doesn't have to be that way.

The NY Health Act will save billions of dollars for patients, employees, employers, health care providers and taxpayers – while providing complete health coverage to every New Yorker.

Everyone would be able to receive any service or product covered by any of the following: NY Medicaid, Medicare, state insurance law mandates, and the current state public employee benefit, plus anything the plan decides to add.

And there will be no premiums, no deductibles, no co-pays, no restricted provider network, and no out-of-network charges.

We'll actually save billions of dollars because we get rid of insurance company bureaucracy and profit, doctors and hospitals will be able to slash their administrative costs, and New York Health will be able to negotiate much lower drug prices by bargaining for 20 million patients.

And this lower cost will be shared fairly, based on ability to pay. NY Health will be funded by broad-based progressively graduate taxes.

There will be one tax on payroll. At least 80% of it must be paid by the employer.

There will be a similar tax on currently taxable "unearned" income – like

capital gains and dividends.

Because of the savings and the progressively graduated tax mechanism, 90% or more of New Yorkers will spend less and have more in their pocket.

Pumping this money back into our economy will create 200,000 new jobs in New York.

And there will be money to completely cover everyone, and make sure doctors, hospitals and other providers are paid fairly – and today, most of the time, they are not.

The vast majority of our hospitals get most of their revenue from Medicaid, Medicare, and uncompensated care pools – none of which fully cover the cost of care. The NY Health Act requires full funding for all hospital care, and hospitals will save billions in reduced administrative costs.

Here are 3 basic numbers: The savings from insurance company bureaucracy and profit, provider administrative costs, and drug prices will total $55 billion. The increased spending for covering everyone; eliminating deductibles, co-pays and out-of-network charges; and paying providers more fairly will cost $26 billion. So the net savings to New Yorkers is $29 billion.

The way our society deals with long-term care – meaning home health care and nursing home care – for the elderly and people with disabilities is a moral outrage. NY's Medicaid does a much better job than other states. But today, New Yorkers spend $11 billion a year out-of-pocket for long-term care. And family members – usually women – provide unpaid home care worth $19 billion.

In January, Senator Rivera and I will be announcing that the NY Health Act will cover long-term care.

Now, that will use up $19 billion of the net savings. But it means no NY family will have to wipe out lifetime savings, and no family member will have to give up a career, to provide long-term care for a loved one. That's profoundly important.

How much tax revenue will we need? With the net savings, we'll need $129 billion from the NY Health taxes. When we add home care and nursing home care, we'll need $159 billion.

How do we know the NY Health program will treat us – and our doctors and

hospitals – fairly? Two ways.

First, the legislation explicitly requires that provider payments be reasonable, related to the cost of providing the care, and assure an adequate supply of the care. No coverage today has that guarantee.

Second, we'll all be in the same boat; rich and poor. Every New Yorker – every voter – will benefit from the program. And every voter will have a stake in making sure our elected officials keep it as good as possible.

Remember where we started: Every New Yorker should have access to needed health care, without financial obstacles or hardship. We're not there today. The NY Health Act will get us there. If anyone doesn't like the NY Health Act, they should either put on the table another plan that will get us there, or admit that they're OK with depriving millions of New Yorkers of health care or family financial stability.

Concerns have been raised by many of NY City's municipal labor unions. They are justifiably proud of the good deal they have won for their members over the years. Good scope of coverage. The City pays the full premium. And the contract says that if there are savings in the health benefit, the savings go into a stabilization fund to pay for salaries and benefits. As they remind us: at the bargaining table they have given up wages and benefits to protect this deal.

Under NY Health, by law, every municipal employee, like every New Yorker, would have an even broader scope of benefits, and without deductibles, co-pays and restricted provider networks and out-of-network charges.

Under the bill now, collective bargaining could continue to have the City pick up the whole tab for the payroll tax and pass on the savings to the stabilization fund. But Sen. Rivera and I have offered to add bill language that by law would require the City to do that, without the need to bargain for it.

Our parents didn't raise us to screw workers. Period. Sen. Rivera and I are determined to make sure that labor's concerns are protected under the NY Health Act. We are continuing the dialogue with them.

Thank you for letting me testify.

New York
HPA
Health Plan Association

90 State Street • Suite 825
Albany, New York 12207-1717
518.462.2293
Fax: 518.462.2150
www.nyhpa.org

December 6, 2018

The Honorable Mark Levine
Chair, Committee on Health
250 Broadway, Rm. 1816
New York, NY 10007

FOR THE RECORD

Dear Chair Levine and members of the committee:

The New York Health Plan Association is a non-profit organization that represents 26 health plans that provide coverage to nearly eight million New Yorkers. The people served by HPA's member plans include individuals who receive coverage through an employer or who purchase it on their own directly through a health plan or through the NY State of Health, the state's Exchange, and residents covered by state programs including Medicaid, Child Health Plus, the Essential Plan and Managed Long-Term Care. On behalf of these plans and the New Yorkers who rely on them for comprehensive, quality health coverage, we are writing to express our concerns about proposals to create a government-run, single payer health care system in our state.

We believe that every New Yorker deserves coverage for high quality, affordable health care, and our member health plans are committed to the state's goal of universal coverage. Our member plans have a long history of working collaboratively with New York government and have been instrumental in implementing the Affordable Care Act and the state's ambitious Medicaid redesign program. This common effort is a major reason for New York's success in insuring coverage for more than 95 percent of state residents and reducing the number of uninsured from ten percent in 2013 to less than five percent today.

The New York Health Act would essentially undo all the progress made to date. Because of the accomplishment of reaching coverage for 95 percent of New York's population, we feel strongly that our collective efforts should be focused on initiatives to build on what's working in health care and fix what's not. Independent analysis of the New York Health Act has shown that a government-run, single payer health system is not the answer.

While the RAND Corporation study of the New York Health Act, undertaken for the New York State Health Foundation and issued in August, suggested that such a system could be feasible, it also noted it would require massive tax increases. Moreover, the analysis assumed that significant reductions in payments to doctors and hospitals would be necessary to achieve the projected savings and the state would be able to obtain the necessary waivers from the federal government—all assumptions that the report called "highly uncertain." A closer look at these assumptions underscores the concerns about a single payer system.

Massive Tax Increases: The proposal would require a tax increase of $139 billion in the first year alone, a 156% increase in what the state currently collects in taxes, and up to $210 billion by 2031. These tax increases would be on top of the $82 billion New York already spends on health care. There is no guarantee New Yorkers—individuals and businesses—would accept the extreme tax increases. Authors of the study noted the potential for tax avoidance, including changes in investment decisions or wealthier people or employers moving out of the state, saying even a small number of people or businesses leaving the state could cause the tax base to collapse.

Cuts to Provider Payments: The savings from a government-run system would come from reducing the reimbursement rates the state pays doctors, hospitals, drug makers and other providers. Hospitals have already voiced concerns about suppression of reimbursement for providers by state programs. Further, the RAND study noted that as a result of lower provider payments, doctors may relocate from the state.

Uncertain Federal Approvals: The state would need to receive waivers from the federal government for both New York's current Medicaid program and to include Medicare beneficiaries in the new system. The Centers for Medicaid and Medicare Services has already signaled it will not grant such waivers for state-based government-run health care proposals.

The RAND report stressed that none of these assumptions are guaranteed. Even if they were realized, the impact of moving from our current health care system to government-run health care would be monumental. Further, the massive tax increases, cuts in payments to doctors and hospitals, and loss of choice, are the reasons groups representing employers, providers and unions have expressed concerns and opposition to a government-run, single payer system.

Residents who like their current coverage—including Medicare beneficiaries, workers with union or employer-based coverage, and individuals enrolled in the Essential Plan—would lose their coverage, as a government run health care system would limit options available to New Yorkers. Even with massive tax increases, patients may still have to wait longer for treatment and there is no guarantee that they would be able to see the doctor or specialist of their choice.

As noted, a government-run, single payer health care system would undo all that New York has already achieved. The focus now should be on measures to provide coverage to the five percent of state resident who are uninsured and making health care more affordable without damaging the health care system and disrupting coverage for those who are covered. Our organizations stand ready to work with you and other elected officials on measures to realize the goal of universal coverage for all New Yorkers.

Sincerely,

Eric Linzer
President & CEO

華人策劃協會 CPC ADVANCING OUR COMMUNITY

Chinese-American Planning Council, Inc.
Testimony at the New York City Council Committee on Health
Hearing on Resolution 470
Honorable Mark Levine, Chair
12/6/16

Thank you Chair Levine and the Members of the City Council for the opportunity to testify today. The mission of the Chinese-American Planning Council, Inc. (CPC) is to promote social and economic empowerment of Chinese American, immigrant, and low-income communities. CPC was founded in 1965 as a grassroots, community-based organization in response to the end of the Chinese Exclusion years and the passing of the Immigration Reform Act of 1965. Our services have expanded since our founding to include three key program areas: education, family support, and community and economic empowerment.

CPC is the largest Asian American social service organization in the U.S., providing vital resources to more than 60,000 people per year through more than 50 programs at over 30 sites across Manhattan, Brooklyn, and Queens. CPC employs over 700 staff whose comprehensive services are linguistically accessible, culturally sensitive, and highly effective in reaching low-income and immigrant individuals and families. With the firm belief that social service can incite social change, CPC strives to empower our constituents as agents of social justice, with the overarching goal of advancing and transforming communities.

To that end, we are grateful to testify about issues that impact the individuals and families we serve, and we are grateful to the Council for their leadership on these issues. Today we are here to urge the New York City Council to pass Resolution 470 in support of the New York Health Act.

1.7 million New Yorkers are currently uninsured, over a million of whom live in New York City The average cost to individuals and families has continued to rise to over $17,500 on average, even with a high average deductible of $2,200. Health care costs have risen at a rate that outstrips income growth, roughly doubling as percentage against income since 2008 for individuals that purchase insurance through their employers. Burdensome costs and lack of access ultimately mean that many New Yorkers do not receive the care they need. At the same time, healthcare costs are ballooning in New York State, growing over $300 billion by 2020. Yet for all the rising costs, the

For employers, the cost has risen 92% over the past decade. High costs of health insurance translate to lower wages, reduced benefits, more restrictive health coverage eligibility and less affordability for employees to take up insurance. Despite high spending for both the state and employers, New York does not demonstrate better quality of care.

華人策劃協會 CPC ADVANCING OUR COMMUNITY

While all New Yorkers are hurt by our broken healthcare system, Asian American Pacific Islanders (AAPI) and other communities of color, immigrants, and low-income New Yorkers are particularly hard hit.

In New York City, AAPIs are the fast growing racial group, and one in five AAPIs do not have access to health insurance. The inequities of access get even more stark when disaggregating data among AAPI subgroups- for example Japanese American have 5.3% uninsurance rate whereas Tongan Americans have a 27% uninsurance rate. At CPC, fully one in four community members that walks through our doors does not have health insurance.

The underinsurance rate is even more severe of an issue than uninsurance. 48% of Asian American New Yorkers lack the income to meet their basic needs, and so many of those who do have health insurance still cannot afford needed medical care. Asian Americans have the highest rate of underinsurance of any racial/ethnic group, at 28%. In human terms, what this means is that even for our community members with insurance, they are making the regular choice between rent, groceries, and going to the doctor or paying for their prescriptions.

In today's political climate, insurance is even more of a fraught issue for those who do not have secure immigration status, or those who have family members that are non-citizens. We have seen community members coming into our centers to de-enroll from government subsidized health insurance because they fear that they or one of their family members may get deported. Many of these community members are on costly, necessary, life-saving prescriptions. Many of them will likely stop their medical care regimens out of fear of having their family separated. The New York Health Act would provide a health care system that does not hold someone's immigration status hostage, creating true health care access for all New Yorkers.

Our current healthcare system is also failing our aging AAPI community members, the fastest growing subgroup of the population. 1 in 3 AAPI seniors lives under the poverty line, and most of our community members have no savings for retirement or long term care. Many are not eligible for Medicare or Medicaid, and have no options for care as they age. Asian American women over the age of 65 have the single highest suicide rate of any group, due to isolation and lack of options. The New York Health Act would provide long term care for these community members.

One of our community members had government subsidized health insurance, but kept putting off needed doctors visits because of the costs. When his condition worsened, and it became clear he had to go to the Emergency Room, he did not want to go because he was afraid of getting deported. This is the cost that our broken healthcare system has on New Yorkers.

We urge the City Council to pass Resolution 470. CPC appreciates the opportunity to testify on these issues that so greatly impact the communities we serve, and look forward to working with you on them.

If you have any questions, please contact Carlyn Cowen at ccowen@cpc-nyc.org.

150 Elizabeth Street | New York, NY 10012 | t: 212.941.0920 | f: 212.966.8581 | www.cpc-nyc.org

India Home
A Center for Senior Care

Commitment to Improve the Quality of Life

Thursday, December 6, 2018

To: New York City Council Committee on Health
From: India Home, Inc.
RE: Oversight - The New York Health Act.

Res 470 - Calling on the State Legislature to pass and the Governor to sign A.4738-A/S.4840-A, legislation that would establish the New York Health program, a universal single payer health plan for all New York State residents.

India Home is a non-profit organization founded by community members to serve South Asian older adults. The mission of India Home is to improve the quality of life for older adults by providing quality care in a culturally appropriate environment. We serve more than 200 older adults across Queens through senior center programs, case management, community mental health programs, recreational activities, and advocacy.

100% of the seniors India Home serves are foreign born and nearly 80% of them have Limited English Proficiency (LEP), which limits their understanding of and access to traditional services. As such, the culturally appropriate services that we and other grassroots organizations provide to immigrant communities are extremely necessary. Our clients come to us from the heavily South Asian neighborhoods of Sunnyside, Jackson Heights, Briarwood, Jamaica, Richmond Hill, and Queens Village. They also live in growing communities situated in the Bronx, Brooklyn, and beyond.

I am here today on behalf of India Home, to voice our support for the New York Health Act. As we know, the New York Health Act will provide comprehensive, universal health coverage for every New Yorker and would replace private insurance coverage. This will have a positive impact on all New Yorkers. This health care act will give every New York resident the opportunity to enroll in health insurance regardless of age, income, wealth, employment, or citizenship status. This is especially important for the South Asian older adults we work with, as they are vulnerable new immigrants themselves who live in poverty, depend on adult children, speak little English, have low-to-no income, and are socially isolated. Access to affordable health care is especially important for our seniors, who face a large amount of health issues (e.g. diabetes, hypertension, heart disease, osteoporosis etc).

Immigrants comprise of almost 50% of New York City's older adults. Many immigrants, including those we serve, require extra attention due to their unique needs. Furthermore, we provide services to many seniors who are also undocumented. These undocumented seniors currently do not have any form of health insurance. This population is growing older, and facing a growing number of health complications and other difficulties. At our Richmond Hill location, we provide senior services, and half of our members there are undocumented. One member in particular, who speaks Punjabi, is undocumented and has lived in this country for more than 30 years. When he's sick, he says he has no choice but to stay at home and rest, because, like most undocumented people, he doesn't have insurance.

178-36 Wexford Terrace Suite 2C Jamaica, NY 11432
Phone: (917) 288 7600 ▪ Fax: (718) 425 0891▪ www.indiahome.org ▪ indiahomeusa@gmail.com

When such seniors need health care services, we refer them to NYC Health and Hospitals Facilities and the emergency room or to Federally Qualified Health Centers, which are also known as Community Clinics. But, community health centers are not adequately equipped to provide extensive care to undocumented seniors specifically. While community and free clinics do a commendable job providing services to undocumented immigrants and others, the health care resources available for undocumented immigrants in this age group are insufficient to cover the need.

This newly proposed legislation establishing the New York Health program would help target these issues by instituting a universal single payer health plan guaranteed for all New York State residents. The coverage will be comprehensive, in that all residents would be covered, regardless of immigration status. This universality would greatly benefit our undocumented seniors, who often feel they do not have access to such essential resources.

Moving forward, we recommend the City Council take the following steps:

1. Create and disseminate informational materials to ensure seniors are aware of their rights to the New York Health program coverage
2. Ensure information is available in the major South Asian languages prevalent in New York City (e.g. Bengali, Hindi, Punjabi, Urdu etc.).

Sincerely,

Vasundhara D. Kalasapudi, M.D.

178-36 Wexford Terrace Suite 2C Jamaica, NY 11432

Phone: (917) 288 7600 ▪ Fax: (718) 425 0891▪ www.indiahome.org ▪ indiahomeusa@gmail.com

nyic
NEW YORK IMMIGRATION COALITION

131 West 33rd Street
Suite 610
New York, NY 10001
(212) 627-2227
www.nyic.org

HEARING ON RESOLUTION 0470-2018 CALLING ON THE STATE LEGISLATURE TO PASS AND THE GOVERNOR TO SIGN A.4738-A/S.4840-A, LEGISLATION THAT WOULD ESTABLISH THE NEW YORK HEALTH PROGRAM, A UNIVERSAL SINGLE PAYER HEALTH PLAN FOR ALL NEW YORK STATE RESIDENTS

NEW YORK CITY COUNCIL COMMITTEE ON HEALTH

Testimony of the New York Immigration Coalition
Presented by Max Hadler, Director of Health Policy

December 6, 2018

Good afternoon. My name is Max Hadler, and I am the Director of Health Policy at the New York Immigration Coalition. The NYIC is an advocacy and policy umbrella organization for more than 200 multi-ethnic, multi-racial, and multi-sector groups across the state working with immigrants and refugees. The NYIC Health Policy program and its Health Collaborative bring together immigrant-serving organizations and other stakeholders from the frontlines of the battle to improve health access.

We are grateful to Councilmember Levine and all members of the Council's Committee on Health for convening this important hearing. The NYIC strongly supports Resolution 470 and has long been a vocal advocate for the New York Health Act because the creation of the New York Health program would have important implications for immigrant communities across the state. New York Health would be available to everyone who resides in the state, regardless of immigration status. From a health coverage perspective, this would be a vast improvement over the current system of piecemeal programming and widespread restrictions that leave 433,000 New Yorkers uninsured because of their immigration status. New York Health would improve the health of all New Yorkers by allowing us to access care when needed instead of rationing based on ability to pay. Fully 98% of New Yorkers are projected to pay less for health coverage and care under New York Health than we do currently.

As we face down a hostile federal government determined to strip New Yorkers of the many health care protections we currently enjoy and sow chaos in our health care systems, the value and security of New York Health is clearer than ever. Along with Make the Road New York, the NYIC leads a sister campaign of the Campaign for New York Health called Coverage 4 All. Through that campaign we are working to protect the coverage of New Yorkers who may soon lose Deferred Action for Childhood Arrivals or Temporary Protected Status, as well as the health insurance protections that come with those statuses. We are also actively pursuing expansions that would make eligible for coverage most of the more than 400,000 New Yorkers who cannot currently

access health insurance because of their immigration status. The New York Health Act would resolve all of these coverage gaps by creating a single universal system of coverage.

While much work remains to make the long-standing dream of the New York Health Act a reality, it is also critical that we begin to think about effective implementation of the program. From the perspective of immigrant communities in New York, this must include strong mechanisms to enforce existing language access laws through the New York Health program. The pervasive segregation in the current health care system by payer and by patient race, ethnicity and preferred language will not be solved overnight without a concerted effort that makes voluntary hospitals and other private providers rise to the level of culturally responsive and linguistically appropriate care currently in place in best-practice organizations like federally qualified health centers.

Appropriate implementation of an eventual New York Health program must also include a well-conceived, well-funded, and well-executed outreach and education program to encourage use of the health care system by immigrant communities that are discouraged from seeking services by virulent anti-immigrant sentiment and the fear and apprehension it causes. As we face walls on our borders, the threatened suspension of asylum, the removal of status from people who have lived in this country for 20 years, major increases in enforcement, and policies like public charge that discourage immigrants from using vital programs and services, we must create a vision for a future of health care access and a welcoming message that ensures that a universal care and coverage system actually lead to equal access and opportunity for all New Yorkers.

The NYIC endorses the Council's adoption of this resolution and the legislation it promotes because it contributes to our vision of a New York state that is stronger when all people are welcome, treated fairly, and given the chance to pursue their dreams. We need a health care system that guarantees access to care as a public good, that is affordable, and that is good for immigrants, seniors, businesses, nurses, doctors, hospitals, and all patients. The New York Health Act moves us closer to that reality.

Thank you to the Council for its work on behalf of immigrant communities, for calling this hearing, and for the opportunity to share this testimony today.

Arab-American Family Support Center

www.aafscny.org

Brooklyn Headquarters
150 Court Street, 3rd Fl
Brooklyn, NY 11201
T: (718) 643- 8000
F: (718) 797- 0410

Queens Office
37-10 30th Street, 2nd Fl
Queens, NY 11101
T: (718) 937- 8000
F: (347) 808- 8778

AAFSC @ the Family Justice Centers
FJC Bronx: (718) 508-1220
FJC Brooklyn: (718) 250 - 5035
FJC Manhattan: (212) 602-2800
FJC Queens: (718) 575 - 4500
FJC Staten Island: (718) 697 - 4300

AAFSC @ The Khalil Gibran International Academy
362 Schermerhorn St,
Brooklyn, NY 11217
T: (718) 237- 2502

Testimony of Arab-American Family Support Center Before the New York City Council Committee on Health
Thursday, December 6, 2018
Rachel Aicher, Development Officer, AAFSC

I want to begin by thanking the Committee on Health and the entire New York City Council for inviting community-based organizations to comment on proposals to ensure access to health coverage for all New York State residents. My name is Rachel Aicher, Development Officer at the Arab-American Family Support Center (AAFSC). As such, I contribute to AAFSC's strategic planning and advocacy efforts. I am honored to testify today on behalf of immigrant and refugee families throughout New York City.

At the Arab-American Family Support Center, we have strengthened immigrant and refugee families since 1994. We promote well-being, prevent violence, prepare families to learn, work, and succeed, and amplify the voices of marginalized populations. Our organization serves all who are in need, but over nearly 25 years of experience, we have gained cultural and linguistic competency serving New York's growing Arab, Middle Eastern, Muslim, and South Asian communities.

As one of the few organizations with an Arabic-speaking Health Navigator in New York, AAFSC has extensive experience expanding access to healthcare for immigrants and refugees. Over the past year alone, we enrolled over 1200 individuals in free or low-cost health insurance programs including Medicare, Medicaid, and essential health benefits under the Affordable Care Act (ACA). We also promote early intervention and preventive care, building community awareness through workshops on diabetes, cancer, and other health issues. This year, AAFSC partnered with the New York City Department of Health and Mental Hygiene (DOHMH) and Maimonides Hospital in Brooklyn to launch a Mental Health Initiative that is building community partnerships to reduce stigma around mental health issues, expand access to treatment for vulnerable populations, and build a strong referral network for community members in need.

We can attest that despite progress under the ACA, there is still unmet need for health coverage among immigrant and refugee communities, and we see disturbing trends. The U.S. Department of Homeland Security's proposed change to the definition of public charge and its implications for immigration status threatens the health, safety, and livelihoods of immigrants and refugees. In light of the resulting fear of deportation, we have already seen our community members give up needed services like Medicaid and Medicare, jeopardizing the health and safety of themselves and their children. We also see families with limited income struggle in the face of rising health

costs and avoid routine interaction with the healthcare system, postponing treatment until problems require urgent care or cannot be helped. Children and the elderly are at heightened risk, but these choices have negative public health implications for our entire city and state.

In light of these observations, AAFSC:

- **Welcomes measures by New York State to ensure that all residents—regardless of age, wealth, income, employment or other status, and including undocumented immigrants—can receive the health care they need.**
- **Applauds efforts to lower health costs and improve outcomes for vulnerable populations, and encourages further action to simplify the maze of health insurance regulations that leave so many families confused and under-resourced.**
- **Reiterates the negative impact that the Department of Homeland Security's proposed changes to the definition of public charge have had on immigrant and refugee populations' willingness to access publicly-funded health services, and the dangerous implications this has for public health.**
- **Respectfully requests that city and state authorities continue to include culturally and linguistically competent service providers like the Arab-American Family Support Center in conversations around community health, to ensure proposed solutions are fully inclusive and optimally designed.**

Thank you for your attention. As always, the Arab-American Family Support Center stands ready to work with you in ensuring the most vulnerable among us thrive.

CACF Coalition For Asian American Children+Families

New York City Council – Committee on Health- Oversight - The New York Health Act.
Res 470 - Calling on the State Legislature to pass and the Governor to sign A.4738-A/S.4840-A
December 6th, 2018

Testimony of Tasfia Rahman, Policy Coordinator
The Coalition for Asian American Children and Families (CACF)

Good Afternoon. My name is Tasfia Rahman and I am the Policy Coordinator for the Coalition for Asian American Children and Families (CACF). Thank you Committee Chair, Council Member Levine for holding this important hearing on the New York Health Act.

For the past 30 years, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need. The Asian Pacific American (APA) population comprises over 15% of New York City, over 1.3 million people. Yet, the needs of the APA community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized APAs. Working with almost 50 member organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

CACF is committed to health equity and works to address the major health issues impacting our diverse communities, namely through our citywide health collaborative, Project CHARGE. We want to ensure that everyone, especially the most marginalized, has access to quality health care. Today, CACF is here along with our members and partners in support of the New York Health Act, which would provide universal health coverage for all New York State residents and will create a truly inclusive and accessible health care system.

This will have a positive impact particularly in NYC, where almost a quarter of Asian Americans live in poverty. Our community is also heavily immigrant with 78% being foreign-born and has the highest rate of linguistic isolation of any group in the city at 42%. The Act will alleviate the burden that many immigrants face in understanding and navigating the complexity of health insurance plans, many of which are too exclusive for families. Additionally, almost 15% of APAs ages 18 and over remain uninsured in NYC and a majority (89%) of APAs uninsured is foreign-born. Many APAs are also self-employed, working in small businesses or in cash-based industries that are less likely to offer health benefits. Healthcare access problems are exacerbated in APA communities by immigration status-related challenges, language barriers, cultural stigmas regarding public benefits, and low utilization of primary and preventive care. In light of the impending Public Charge Rule, we need cannot afford to dismiss an opportunity to protect and improve the health and well-being of our immigrant communities. NYHA (not one of the means in the Public Charge test) combats the revisions to the Public Charge Rule directly and would allow a significant portion of New York's community to access healthcare without fearing threats against their immigration status.

CACF makes the following recommendations to the City Council:

1. Please call on the New York State legislature to pass the New York Health Act and the Governor to sign it into law.

2. We also urge City Council to ensure that the community and organizations serving APAs are included and supported in the outreach efforts during the implementation of the Act. Considering that high levels of fear, confusion, and stigma are attached to utilizing public benefits and the high percentage of Limited English Proficient (LEPs) in our community, effective outreach is necessary for the successful implementation of the Act.
3. CACF also asks City Council to guarantee that the New York Health Act provides a thorough and inclusive coverage, which provides care often overlooked in basic health insurance such as dental, eye care, and mental health care that is both language accessible and culturally competent.

Thank you so much for taking the time to hear our testimony. We appreciate your commitment to improving the health and well-being of APA children and families in New York City. CACF looks forward to working with you and your office to ensure that our communities are receiving coverage for the high-quality healthcare they deserve.

50 Broadway, Suite 1001, New York, NY 10004
212.668.0050 » naswnyc.org

NASW | NEW YORK CITY CHAPTER
National Association of Social Workers

NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW-NYC)
New York City Chapter
President of the Board: Mr. Benjamin Sher
Executive Director: Dr. Claire Green-Forde
Associate Director: Olanike Oyeyemi

NEW YORK CITY COUNCIL HEARING
ON THE NEW YORK HEALTH ACT
Resolution 0470-2018
December 6, 2018

Mr. Chairman
Distinguished Council Members

The National Association of Social Workers NYC Chapter appreciates this opportunity to speak on behalf of **resolution 0470-2018** that expresses the Council's support for the New York Health Act. In fact, our Association has already expressed its support for the Act directly to legislators in Albany.

We represent 6000 social workers in the metropolitan area. Social workers are on the front line of the fight for universal affordable healthcare because we deal on a daily basis with the **problems** our clients experience i.e. when they become sick and are without insurance, have inadequate coverage, cannot keep trusted providers because their employers change their insurance plan, or they cannot afford the bills even if insured. Social workers know too well the profound **anxiety** of patients and their family having to deal with insurance companies limiting or denying treatments ordered by their doctor or facing bankruptcy because of medical bills. Because social workers always focus on the person in his or her environment,

we understand the impact poor healthcare has on mental health, employment since patients may lose their jobs when they delay treatment because of costs and then face hospitalization or lengthy rehabilitation. Clients can lose their housing because of unpaid bills. Stress due to financial debts can negatively affect relationships with a partner or spouse and children resulting in loss of emotional support when they need it most.

How long must we hear in our work: "I am insured but the deductibles are too high and one of my specialists is out-of-network. I can't afford to see both this month: one is a surgeon (out-of-network) who fixed a botched ankle operation, the other is my oncologist"?. How much longer must we tolerate a situation such as this one reported by a social worker: a 50 year old client needed a feeding bag to bypass his stomach for about 3 months before and after surgery; his elderly father continued his expensive private insurance although the client no longer had an income; the large and wealthy insurance company cut off the feeding bags, defined as "skilled nursing" because they only provided 30 skilled nursing visits a year; at over $1000 a day for his prescribed mixture of nutrients, this man could not cover the cost of his treatment; he was therefore forced to apply for Medicaid, having exhausted his resources, to ensure coverage of the cost of the other two months of feeding bags. How long will we tolerate as a rich country the horrors that can occur when residents are uninsured, for example a man complaining of pain in the lower right abdomen who died of a ruptured appendix before reaching the age of 30 because he could not afford to go to the emergency room since he was uninsured, a third world problem?

We recognize that the Affordable Care Act brought insurance to millions of people. However, the statistics on the number of people insured does not reveal the fact that **many are underinsured** because of high deductibles and out-of-pocket costs; therefore, they do not seek medical care, waiting until the condition is critical. Countries with universal healthcare found that spending more on prevention and early intervention is indeed economical.

How long must we witness in NYC two different systems of care, one for the wealthy or well-insured and the other for the economically disadvantaged? Those who have Medicaid, do not have a choice of where to get medical care. Many providers, because a low reimbursement rate, refuse to see patients on Medicaid and increasingly on Medicare. Some hospitals who receive funds to help the poor nevertheless steer these patients to public hospitals which are overcrowded and underfunded. This affects in particular minorities and results in New York City having one of the **most segregated health systems**, as a recent study has shown [i].

Social workers and their clients face a complex and fragmented system, having to deal with Medicare, Medicare advantage plans, Medicaid and its various plans, Chip, and hundreds of different plans by a multiplicity of insurance companies. Imagine instead a single payer system with the ability to negotiate prices with pharmaceuticals and device companies and which would enable social workers and providers to focus on their mission.

The question then becomes, how much longer do we, as a society, have to wait before we can deliver a fair, simple, affordable healthcare system to our residents, when every other

rich country has done so? Studies at the Organization for Economic Co-Operation and Development, an organization of 36 among the richest market-economy countries, show that the United States spends twice as much per capita as the other countries with poorer outcomes and the price of drugs is much higher than in other countries. Why? Should we blame insurance companies and pharmaceuticals for having as a priority the profit motive and the concerns of shareholders? That is the nature of private companies. What we support is taking out the profit motive from healthcare and adopting a single-payer system as recommended in the New York Health Act.

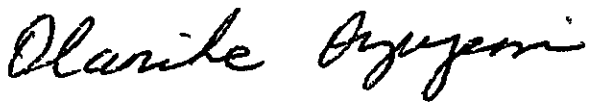
We can no longer use as an excuse that New York State cannot afford it. Two studies have demonstrated that we have the resources to pay for such a system: the first was by Professor Gerald Friedman, Chair, Economics Department, University of Massachusetts at Amherst in 2015, the second by the Rand Corporation in August 2018 which stated, furthermore, that long-term care could be added to such a plan. Nor can we accept the argument that taxes will increase. We are already paying a "tax" in the form of premiums, deductibles and out-of-pocket costs. Under the New York Health Act, 90% of New York State residents will pay less for healthcare.

Dr. Martin Luther King stated: "Of all the forms of inequity, injustice in healthcare is the most shocking and inhuman." We agree and believe that the solution rests with our elected officials who can decide that the misery inflicted on New Yorkers is no longer acceptable and that it is time to adopt a solution that every other wealthy country has adopted:

a truly affordable universal healthcare. The solution is there, it is the New York Health Act. What is needed now is the political will to implement it.

The National Association of Social Workers New York Chapter therefore hopes that the New York City Council, representing millions of New Yorkers, will add its voice to the many communities large and small in our State who have expressed support for the New York Health Act and have asked our elected officials to act at last.

Thank you for your attention.



Olanike Oyeyemi, LMSW
Associate Director
NASW- NYC Chapter

Benjamin R. Sher, MA, LMSW
President of the Board of Directors
NASW- NYC Chapter

[i] *Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York* City by Roosa Sofia Tikkanen, Steffie Woolhandler, David U. Himmelstein, Nancy R. Kressin, Amresh Hanchate, Men-Yin Lin, Danny McCormick and Karen E. Lasser. International Journal of Health Services, 0(0) 1-17, 2017R

NEW YORK CARING MAJORITY
www.nycaringmajority.org

Testimony before the New York City Council Health Committee
Thursday, December 6, 2018

Karla Lawrence, National Domestic Workers Alliance & the New York Caring Majority

Good afternoon. My name is Karla Lawrence. I am a proud member of the National Domestic Workers Alliance and SEIU 1199. I am here today testifying as a steering committee member of the New York Caring Majority.

I grew up in Jamaica, as one of 4 siblings. Like so many girls and young women, I grew up caring for my siblings and for the aging members of my family and community. That's simply what we did. I took care of my grandmother in Jamaica for several years, and I look back on our relationship with great love and pride. Even when others sometimes didn't understand her needs, she and I were always very close and I always felt tuned in to her needs for dignity and care. I also was a caregiver for my father in the final months of his life after he suffered a series of heart attacks. I'm proud that he was able to pass away peacefully and with dignity.

I immigrated to New York in 1991 when I was 16 years old. I finished high school, and when it came time to begin pursuing work, I chose home care. I remembered how it felt to care for my beloved grandmother back home, and realized that I had a passion for this work. I signed up for a course and became a home attendant right out of high school. With each client that I took care of, my passion for caregiving grew.

I worked for eight years as a home attendant before deciding that I was ready to take the next step in the career ladder. I went back for more training to become a CNA, enabling me to perform more caregiving duties than before. Today I'm proud to share that I have gone back to school for nursing.

NEW YORK CARING MAJORITY
www.nycaringmajority.org

Every day in New York, hundreds of thousands of domestic and care workers ensure that babies and young children are given the highest quality of care, seniors and people with disabilities can live independently in their own homes, and many working professionals who hire cleaners can maximize their working and personal time and live in healthy homes. Despite our important work, across the country, domestic & care workers often don't make enough to feed our own families; face high rates of injury on the job; and lack healthcare and paid leave. We are a community that will truly benefit from the New York Health Act, would create a single-payer program that provides universal, comprehensive health care to all New Yorkers.

However, any new health care system that does not include a strong and complete approach to long-term care will ultimately leave many behind, such as our workers who are aging without any form of security, and also the families and individuals who employ us. To be a truly universal system, it must, from day one, include a new long-term care benefit that meets the needs of older adults and people with disabilities by increasing access to home and community based services. Having a home care worker like me can prevent unnecessary falls and hospitalizations, not to mention ensuring that seniors are eating well and taking their medication on time. Home care workers are vital in preventing these costly and unnecessary setbacks. New Yorkers are aging rapidly, and by 2024, New York State will need 23,000 more home care workers.

I urge members of the City Council to vote yes on this resolution. New York needs to make quality single-payer health care that guarantees long-term care to aging New Yorkers and people with disabilities a reality for our communities.

CALLEN-LORDE

TESTIMONY BEFORE THE NEW YORK CITY COUNCIL COMMITTEE ON HEALTH
December 6, 2018

Submitted by Kimberleigh Joy Smith, MPA
Senior Director for Community Health Planning and Policy

Good Afternoon. Thank you - Speaker Corey Johnson, Chair Mark Levine and Members of the New York City Council Committee on Health - for the opportunity to testify before you today. My name is Kimberleigh Smith, and I am representing Callen-Lorde Community Health Center.

Callen-Lorde Community Health Center is a federally-qualified community health center, whose mission is to reach lesbian, gay, bisexual and transgender communities as well as people living with HIV in New York City and beyond with high-quality, comprehensive, non-judgmental healthcare regardless of ability to pay. We are a vibrant part of New York City's dynamic healthcare infrastructure and last year we cared for nearly 18,000 patients.

We are here today to publicly endorse and urge the New York City Council to pass Resolution 470, a resolution in support of the New York Health Act, state legislation to create a universal, single payer healthcare system in New York State. As a nationally and internationally-recognized community healthcare facility that was born out of the Stonewall Era – at a time when the mainstream medical establishment did not fully embrace or acknowledge the primary and sexual health needs of the LGBTQ community; we believe we hold a particular expertise in how to make healthcare fully equitable and accessible to all. We want to offer today our support for this resolution as providers, as employers and as principled proponents of health, economic and racial justice.

Since its inception, Callen-Lorde has upheld the value that healthcare is a human right and that true liberation will only come when the LGBTQ community and our families can adequately access culturally competent and comprehensive health care in all forms. For Callen-Lorde this is a value that is manifested in practice every day for many of our city's most vulnerable citizens. In 2017, nearly one-third of our patients were uninsured and more than a third are publicly insured. Nine percent are homeless or do not have stable housing. Twenty-percent are living with HIV making Callen-Lorde one of the largest non-hospital based, HIV care providers in New York City and State. And 65% are under the age of 40.

Even after the ACA was implemented, at least 15% of LGBTQ people remain uninsured, according to the Center for American Progress. It is estimated that in New York State, 1 to 1.5 million people are uninsured. While Callen-Lorde provides care regardless of a person's insurance status, the demand for our affordable, sensitive and quality healthcare outpaces our capacity. For low-income and otherwise marginalized communities, like LGBTQ communities, this translates to poor health outcomes. And, in general, health disparities exist for our communities. For example, lesbians are less likely to get preventive cancer services, men who have ex with men are at greater risk for HIV, especially in communities of color and transgender patients are still denied gender-affirming care.

As providers of health care, Callen-Lorde believes that a single payer health system will enable us to focus more time and energy on patient care, implement innovative prevention interventions and conduct more outreach in communities. This undoubtedly will improve our patient outcomes. Though technically not constrained by a patient's insurance status because of our standing as a community health center, we still suffer the inordinate burden of wrangling with commercial and public insurers, navigating complex billing systems and untangling administrative bureaucracy. The simplification of using a single formulary will reduce the significant time and administrative burden currently placed on prescribers using multiple formularies and having to submit endless prior authorizations. Currently, we spend hundreds – possibly thousands – of hours of staff time helping our transgender patients contest insurance denials for gender-affirming care, care that is medically-necessary and mandated to be covered both by Medicaid and commercial insurers in New York. Last year we supported a gay male patient whose insurance lapsed and thus he lost his PrEP prescription. He was not eligible to receive support through the state's assistance program and sero-converted while uninsured and not on PrEP. There are countless examples like these. A streamlined, stable single payer health care system in New York would value clinical judgement and autonomy over arbitrary cost cutting.

As an employer, we believe the New York Health Act will create savings that can be reinvested back in to patient care and our workforce. Earlier this year, Callen-Lorde conducted a basic analysis to help enumerate the potential benefit of the New York Health Act. We took the cost of our current employee based health care plan (of which Callen-Lorde pays 100%) and added that to the cost of an estimated percentage of current administrative expenses, that which are necessary under current healthcare system, such as billing, chasing payers (including public and commercial insurers), insurance enrollment and navigation, etc. Using Dr. Gerald Friedman's *Economic Analysis of the New York Health*

Act[1], we determined how much Callen-Lorde would incur for 100% of our employees' health care based on his analysis of the cost of care by annual income. This amount was far less than our current cost of health care and administrative costs. We determined that a New York State single payer system could yield $3.5 million in savings annually for Callen-Lorde.[2]

Saving money on our current medical plan for employees and simplifying administration and paperwork, our analysis shows that Callen-Lorde could then **reinvest $3.5 million dollars** back in to our workforce and patient care.

Finally, we support a single payer health care system because it will advance health, economic and racial justice in our city and state. Fragmented and commodified, New York's healthcare benefits system – more generous than many states – still treats health care as something that is only available to people who are insured, employed, wealthy or all of the above. Marginalized people and people without means theoretically can access healthcare in our state's community health clinics, but demand outpaces supply and our clinics still by and large exist in an infrastructure that does not favor the low-margin, community health care model. The single payer framework for healthcare recognizes healthcare as a universal necessity, not on driven by profits, incentives and social status. Single payer may not cure all the ills of our society, but it would be a potent dose of healthcare equity.

Thank you for the opportunity to submit testimony today. Please feel free to call upon Callen-Lorde as a resource on community healthcare. For more information, please contact me directly at ksmith@callen-lorde.org or 212-271-7184.

---

[1] Gerald Friedman, PhD, *Economic Analysis of the New York Health Act*, University of Massachusetts at Amherst, April 2015, Overview, Savings through New York Health vs. Employer-based Health Insurance, page 2.

[2] For more information, contact Kimberleigh J. Smith at ksmith@callen-lorde.org or 212-271-7184.

Testimony

New York City Council – Resolution 470

New York City Council – Health Committee Hearing
Chair, Mark Levine

December 6, 2018

Committee Room, City Hall
New York, New York

Charmaine Ruddock, MS
Project Director, Bronx Health REACH
212-633-0800 ext. 1291
cruddock@institute.org

Introductions
Good afternoon. I wish to thank the City Council and its Health Committee for this opportunity to provide testimony in this hearing on Resolution 470 in support of the legislation A.4738-A/S.480-A to establish the New York Health program, a universal single payer health plan for all New York State residents.

Background
I am Charmaine Ruddock, the Project Director of Bronx Health REACH, a coalition of 70+ community and faith based organizations in the Bronx. This Coalition is led by the Institute for Family Health, a network of 30 Federally Qualified Health Centers in the Bronx, Brooklyn, Manhattan and in Ulster and Kingston counties in upstate New York. The Institute serves 117,000 patients and do 650,000 patient visits each year.

Bronx Health REACH's focus since its inception in 1999 is the elimination of racial and ethnic disparities in health outcomes, especially in the Bronx. Much of our work in the community has focused on diabetes, and its prevention which disproportionately impacts Bronx residents for a number of reasons, including access to health information, access to healthy lifestyle choices and access to health care. By almost every health measure, the Bronx has the poorest health outcomes in New York. For the past nine years, the Robert Wood Johnson County Health Rankings Report has ranked the Bronx 62 out of the 62 counties in New York State in health outcomes and health factors. It is why Bronx Health REACH, The Bronx Health Action Center formerly the Bronx District Public Health Office, Montefiore Health System, The Bronx Borough President's Office co-founded Not62: The Campaign for a Healthy Bronx.

I. Some statistics

a. Within New York City, the Bronx has the largest percentage of adults without health insurance (22%), and
b. the largest percentage of adults going without needed medical care (12%).

The work of the Coalition has involved multiple focus groups with community residents to determine the obstacles they encounter in getting good health care and living long healthy lives. The themes that emerged regarding the health care system that people encountered as they tried to get care were as follows:

1. Distrust of the healthcare system
2. A sense of being disrespected by the system
3. Poor Communication
4. Feeling of inadequacy in advocating for themselves

The findings were used to develop community-based initiatives on nutrition, fitness, and diabetes education among others. However, through these efforts we also recognized that while these community efforts were valuable and, can and do make a difference; in order to have the change that will ensure sustainable health for Bronx residents, access to quality healthcare had to change.

As we examined the causes of widespread racial and ethnic health disparities in health care and health outcomes in our community and in fact across the state and the nation we found pervasive segregation of care based on the link between race, ethnicity and insurance status, resulting in the systematic separation of whites and people of color into different systems of care. We called it Medical Apartheid.

- We found differences in health insurance coverage by race.
- Segregation of the Poor and Uninsured into different institutions
- Segregation into Different Care Systems within Institutions
- Inequities in Payment by Public Insurance Programs
- Failure of Medicaid Managed Care to Eliminate Disparities in Care
- Institutional Subsidies for Care for the Poor and Uninsured that too often have limited mitigating effect on the cost the poor and uninsured are charged for the care they receive

Legislation A.4738-A/s.4840-A if passed will have a profound impact on changing all of this. It will mean that people in the south Bronx will be able to access the same quality of healthcare as people just a few zip codes away from them whose care now looks very different from theirs and whose outcomes, in many instances, as a result, is different from theirs.

Closing

In conclusion, the Bronx Health REACH Coalition and the residents of the Bronx are not naïve to believe that the establishment of the New York Health program will be the magic bullet that in one fell swoop eliminates racial and ethnic health disparities. However, we do know that it will certainly eliminate a major obstacle in achieving that goal.

The Bronx Health REACH Coalition urges the City Council to pass Resolution 470. It will be part of your legacy in support of Not62: The Campaign for a Healthy Bronx.

NYLPI

JUSTICE THROUGH COMMUNITY POWER

Testimony of Yleana Roman, Health Justice & Immigration Staff Attorney
On behalf of New York Lawyers for the Public Interest
to the New York City Council's Committee on Health

Good afternoon, my name is Yleana Roman, and I am the Health Justice & Immigration Staff Attorney[1] at the New York Lawyers for the Public Interest. Thank you to Chairperson Levine and the Committee members for having this oversight hearing.

NYLPI supports the passage of the New York State Health Act, legislation that would establish the New York Health program, a universal single payer health plan. NYLPI urges the State Legislature and the Governor to pass and sign the New York Health Program since it will cover undocumented immigrants who need healthcare.

I. New York Lawyers for the Public Interest

For the past 40 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights and legal services advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual legal services, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to create equal access to healthcare, achieve equality of opportunity and self-determination for people with disabilities, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color.

Our staff of 33 includes lawyers, community organizers, social workers, legal advocates, development professionals, and administrators.

In the past five years alone, NYLPI advocates have represented thousands of individuals and won campaigns improving the lives of millions of New Yorkers. Our work with community partners has led to landmark victories including deinstitutionalization for people with mental illness; access to medical care and government services for those with limited English proficiency; increased physical accessibility of New York City public hospitals for people with disabilities; cleanup of toxins in public schools; and equitable distribution of environmental burdens.

In addition, NYLPI's Pro Bono Clearinghouse provides critical services to strengthen non-profits throughout every community in New York City. Drawing on volunteer lawyers from New York's most prestigious law firms, we help nonprofits and community groups thrive by providing free

[1] Admitted in New Jersey.

legal services that help organizations overcome legal obstacles, build capacity, and develop more effective programs. Through educational workshops, trainings for nonprofit leaders, individual counseling and a series of publications, the Clearinghouse is at the forefront of helping nonprofits maximize their impact on communities in each of your Districts.

II. NYLPI's Health Justice Program's efforts as part of the Immigrant Health Initiative

NYLPI's Health Justice Program brings a racial justice and immigrant rights focus to healthcare advocacy in New York City and State. NYLPI is privileged to be part of the City Council's immigrant health initiative and we thank you for that support. Through this funding the Council supports our UndocuCare program. As part of the program, we have been able to train and give presentations on immigrant access to healthcare to hundreds of community-based organizations, health care providers, and legal services providers. We continue to provide comprehensive screenings, and representation to individuals, particularly those who are in health emergencies. NYLPI has had the flexibility to adjust and tailor the program according to the needs of the community and to be responsive in these changing times. NYLPI works to ensure that immigrants have access to healthcare. Without access to health coverage, many of our clients would not be able to survive.

We screen many clients in our UndocuCare program with serious health conditions, who unfortunately do not have any immigration relief available to them. For instance, we had a potential client who was 22 years old when he came to us for help. The client had a growth deficiency and needed Medicaid for treatment. Unfortunately, he did not qualify for immigration relief. If we were able to submit an immigration application on his behalf, then the client would have been PRUCOL and could have had the ability to obtain much needed care. Sadly, this was not the case and he continued to suffer. Many undocumented individuals are similarly situated and unable to make their presence known to immigration and so cannot become PRUCOL eligible and cannot have access to life-saving healthcare.

Unfortunately, we regularly see New Yorkers with serious health conditions in the same situation, ineligible for immigration relief and ineligible for any healthcare beyond Emergency Medicaid. In fact, there are approximately 400,000 undocumented immigrant New Yorkers who do not have any kind of healthcare coverage. Additionally, there are hundreds of thousands of additional New Yorkers who fall between the cracks and are unable to access coverage. Further, having coverage does not always mean access to comprehensive or quality coverage that addresses the person's real needs in an affordable way. The New York Health Act could change that and provide needed healthcare to these individuals, and in doing so, save lives.

III. The New York State Health Act could ameliorate the impact of the proposed federal public charge regulation.

As many of you have heard, the Federal Government has proposed a public charge regulation that will dramatically change how the Department of Homeland Security (DHS) adjudicates certain immigration applications. The federal government's proposed regulation is having, and will continue to have, a chilling effect on immigrants accessing healthcare. Even those immigrants who

are eligible and can access healthcare and will not be subject to this charge, are frightened. NYLPI predicts that many immigrants will not renew their health insurance or not apply for healthcare at all. Thus, a statewide health act that covers all individuals regardless of immigration status and income could help to combat the federal regulation's impact and its chilling effect. It would also cover those immigrants that would in fact be affected by the regulation and show that New York State believes in our communities' health.

Additionally, outreach to immigrant communities and thoughtful implementation with respect to those communities are important to address the chilling effects and to the overall success of the New York Health program. A concerted and large outreach effort to immigrant communities, who are already intimidated and less likely to apply, is necessary to encourage use of the New York Health Program. It will also be crucial that the program have structures in place to enforce existing language access laws and ensure that the care provided is linguistically accessible to all.

IV. Conclusion

Our leaders must pass strong, affirmative legislation that protects all New Yorkers and supports the undocumented immigrant population in New York. Therefore, we support the New York State Health Act.

Thank you for your consideration today. We look forward to continuing to work with the Council to improve immigrant New Yorkers access to healthcare. Please feel free to contact me at (212) 244-4664 or yroman@nylpi.org for further information or discussion.

Academy of Medical & Public Health Services

5306 Third Avenue, Second Floor, Brooklyn, NY 11220
General Information: (212) 256-9036 | NYC Center: (646) 543-3060
Email: info@amphsonline.org | Website: www.amphsonline.org

Testimony on the New York Health Act
December 6, 2018

Mon Yuck Yu

Good afternoon. My name is Mon Yuck Yu, and I am the Executive Vice President & Chief of Staff at the Academy of Medical and Public Health Services (AMPHS). AMPHS is a not-for-profit healthcare organization in Sunset Park that provides free health screenings integrated with individualized health education and social services to the immigrant populations of New York City. Our mission is to deinstitutionalize healthcare, tackle the social determinants of health affecting our immigrant populations, and make healthcare a basic human right for all New Yorkers. We provide our services free of charge and without discrimination to documentation status, socioeconomic status, and any other demographic factor. In the past eight years we have been operating, we have grown right alongside implementation of the Affordable Care Act and NYS Medicaid Reform, and the importance of universal healthcare access cannot be clearer.

I want to start off by telling you the story of one of our community members, Rosa.

At 44 years old, Rosa has faced a lifetime's worth of obstacles. Rosa was born and raised outside of Mexico City. She was working as a special education teacher when she was diagnosed with thyroid cancer in her 20s and could only access very limited medical care. Like many of the community members whom we see at AMPHS, Rosa is a survivor of complex trauma – she and her family have had several frightening encounters with gang members and a former boyfriend was even murdered – but she never received mental health treatment and suffered in silence.

Coming to New York was the only way for Rosa to find safety for herself and her family. Rosa was apprehended twice after crossing the border. She was detained for approximately one month; without the medications that she requires for her thyroid and other conditions, she greatly decompensated and nearly died.

But Rosa never stopped fighting. Not even after making it to NY, where she suffered an operative complication that left her molars fractured, which has led to substantial tooth pain and most recently, migraines. Or when an abusive former employer withheld her wages and threatened her when she tried to file a police report.

Rosa presented to AMPHS seeking help managing her chronic medical conditions. She met with our clinician to review her medical history and symptoms and obtained guidance about next steps. Our social worker and community health worker have helped her transfer her care from a private institution to a public facility, where obtaining needed medical services is less costly. We helped connect her with a dental school clinic, so that she can begin long overdue dental work. We contacted local pharmacies to help her find the best prices for her prescriptions because she

frequently had to skip doses of her medication, which has had a detrimental effect on her health. We educated her about her rights if faced with immigration enforcement. We provided supportive counseling while she opened up about her history of trauma for the first time ever.

But with these integrated social services, Rosa is still struggling to make ends meet. Her $800 monthly income hardly supports her living expenses, not to mention follow-up dental care, the $3000 fee of which she cannot yet afford. And even though Rosa now knows that there are mental health treatment opportunities available, she cannot yet afford the weekly $20 fee.

This is the profile of the community members we see -- whose rights are taken away from them, who want to fight back, but don't know how to. Who suffer from the pain of deteriorating health in silence and don't know where to turn. Far too often, community members like Rosa forgo critical care due to the lack of health coverage. A condition as simple as a molar fracture can mean that an individual loses the ability to eat a nutritious meal, leading to conditions like diabetes, anemia and osteoporosis -- affecting their quality of life at work, in school and at home.

Now, more than ever, augmenting numbers of immigrants are falling into this healthcare gap. Federal immigration threats such as the dismantling of DACA and termination of Temporary Protected Status means that immigrants may no longer have access to Medicaid. Undocumented immigrants remain ineligible to be covered under public health insurance, while undocumented youth are losing their health insurance coverage as soon as they turn 18 years of age. Proposed public charge regulations are also discouraging immigrants from applying for healthcare benefits.

Immigrants that already suffer from post-migration trauma as a result of detention centers, violence, immigration proceedings, and cultural adaptation to a new language and environment must now face the fears of deportation, family separation, and discrimination. Together, these risk factors contribute to aggravated physical and mental health statuses of our communities, without recourse. Emergency Medicaid hardly covers the necessary medical services outside of emergency needs, including mental health therapy and psychiatric care, which affect more and more immigrants every day.

Despite changing social and political times, the AMPHS health service center remains a haven for our community to engage in a broader dialogue about their overall health and wellness and advance health equity as a matter of social justice. By developing coordinated interventions in three program areas—clinical services, social and counseling services, and training and education—AMPHS aims to address the root causes contributing to the health disparities and poor outcomes facing our immigrant populations today. Our work is in prevention and care coordination. But when there are gaps in the system, this model cannot work – coordination cannot work when our healthcare system fails to open the bridge to provide equitable access to all.

It is in times like these that the New York Health Act is both timely and essential. Healthcare is not a privilege, but a basic human right. All New Yorkers deserve equitable access to medical care, no matter how much they make, where they are from, or how they look. Healthcare for all makes our populations healthier, so people can go to school and find work and contribute to our economic growth. It makes us stronger as a society.

Thank you.

Good afternoon, my name is Colette Price Swietnicki
I'm a retired Nurse-Midwife and I've worked for Health and Hospitals for the past 30+ years.

Over those years I've watched "health caring" disintegrate into financial efficiency packages of what today passes for a health care system.

To all those who's vision is not clouded by insurance company checks and propaganda, the NYHA is a no-brainer.

It is affordable, can provide care for every New York State Resident and may even save money. The studies have been done.
First by Professor Gerald Friedman, economist from UMass Amherst back in 2015. To some, his left-leaning politics made his analysis suspect.
But then along came the Rand Corporation (hardly a bastion of radical thought) inadvertently proving the same thing.
They said, yes, we can cover everybody, and yes, it's affordable, before adding their ambiguous caveats: it will save New York money, but it will cost more.
In fact, the majority of news media did the same thing. It's affordable, but your taxes will go up. Never of course pointing out that these progressive taxes will take the place of your premiums, deductibles and out of pockets costs, which probably don't come close to adding up to what your new taxes would cost.
Yes, some people would pay more, the rich or very rich. That

is the top 10%; but 98% of New Yorkers will see a cost savings.
Does that make us anti-rich?
Well no, unless you see a progressive income tax as being anti-rich. It's paying your proportionate share. When your pie is bigger, the cost of that piece is also bigger.

And, if you want to talk inequities viz-a-viz the rich here's one pointed out by billionaire Warren Buffet . In a NY Times op-ed Buffet confessed that although his salary was many times larger than that of his secretary, they both paid the same premium to their health insurance network. Why? Because the larger number of employees created the larger pool, which made premiums affordable for everybody. Is this a case of the working class subsidizing the rich?

We might be warned we had better treat our millionaires nicely or they'll move away. Really? You think finance capitalists are going to move from the finance capital of the world? Where are they going, Timbuktu? And as a matter of fact other state surveys have already debunked this myth.

There are numerous benefits to NY State from the New York Health Act and savings as well. Medicaid payments for example. Medicaid is uniquely financed in NY State by payments from counties. Counties (upstate, downstate and rural -who's representatives, I might add, have not looked kindly on the bill) raise the money for Medicaid by increasing property taxes. In some counties medicaid

spending as a percent of property tax was 80.9%. The NYHA by providing one coverage plan, thereby eliminating medicaid payments, will save counties billions.

Council people:
We don't need health insurance-- We need health care. But we can't even approach the job of putting together the best health **care** system for every New York resident until we can get through this morass of health mongering and profiteering. Please help us get the NYHA passed now!

Thank you.

Colette Swietnicki

Sharon Rae Kahn, Ph.D
1619 Third Avenue, #23B
New York, NY 10128
(212)996-0060
NYS License: 011970-1

December 6, 2018:

Honorable Members of the City Council: I wish to testify about my experiences as a senior psychologist at CIH from 1997-2003 as well as my current experience as a medical expert in psychology for the Social Security Administration

When I started at CIH in 1997 in the Child Psychiatry Department, we offered many programs to the community at large that had nothing to do with mental maladjustment. We offered programs to help children with reading and literacy problems. These programs were free to children who lived in the zoned area. These programs were free to members of the community. Participation in these programs did not involve an intake or require a psychiatric diagnosis. Children do not like receiving a psychiatric diagnosis. It is difficult enough to engage them if they feel they have to participate because they are bad. They are easier to engage if it is an after school program. After school programs are relatively normal. However, by early 1998, this program and all such programs were abolished. Any programs offered by CIH had to be reimbursed by insurance. And, this privileges medication over relationships. No behavioral problem is cured by medication alone. Children need relationships to maintain stability or even thrive.

So even 20 years ago, we see what happens when insurance dictates intensity and form of treatment and use of insurance requires a diagnosis of some sort. In my current job, I function as a medical expert for social security I review cases which involve every hospital and outpatient treatment facility in NYS. In every case, I see doctors document that "patient was discharged from this clinic, as we no longer take his insurance." Or, patient has not been on medication for the past three months. He informs that insurance would not cover this medication." Or "physician phoned the insurance company. Insurance company will not cover the medication unless the patient fails covered medication." Fails in mental health means the patient is at risk for harming themselves or others. Failed means this person will not be able to work or attend school because they will probably be inpatient, which means the patient may lose their insurance coverage. Then, patients are discharged from inpatient units after a day or two because "insurance determined they were not in need of that level of intensity and can be safely treated on an out-patient basis. So, let's review—if the outpatient facility takes their insurance, they can't provide the medication the patient requires. If the patient decompensates, the insurance company tells the hospital they are not suitable for that level of treatment and forces their release. If they miss work because of in-patient, they may lose the insurance itself, and thus, access to treatment. Why are we letting an insurance company tell us how to treat a patient or that the patient is now "stabilized." Within two or three days, patients are not "stable on medication." They are zombified personas—sometimes drooling, sometimes unsteady

on their feet, sometimes dazed by intensive exposure to antipsychotics. They do not acknowledge they have a problem. Release them in two or three days, they immediately stop their medications---the medications do not make them feel better, just dead inside. The medications may cause impotence, weight gain, over-sedation, stomach-aches, and dental caries. They may commit suicide. They may harm another. They may return to substance abuse. They may return to families which do not understand what has happened to their child or parent and have no idea how to respond to the member. Worse, the patient may be discharged to a homeless shelter, which is certainly no place to facilitate recovery. This has nothing to do with treatment. And why? Because insurance only covers medical needs. Psychiatric patients require relationships to maintain their stability or even thrive. And no doctor stands up and says—how many years of treatment experience with disturbed patients has this insurance spokesperson had? Had many years of graduate school did this spokesperson complete? Has this spokesperson gone through board certification or licensure in mental health needs?

We need to stop treatment by insurance companies. We need to boldly acknowledge that the purpose of insurance is to make profits, not proffer treatment. Psychologists, psychiatrists, and social workers proffer treatment. And our decisions need to be unfettered from the chains of insurance dictators. Thank you.

Health Story Testimonials
In support of Resolution 470
Offered to NYC Council Health Committee on December 6, 2018

Financier. Well insured. Motorcycle hit-and-run. Maxed insurance. Bankrupt.

He had "Cadillac" health insurance. Then disaster struck on a Sunday morning on a quiet NYC street: a speeding motorcyclist hit him, breaking every bone on the right side of his body. Saving his life and repairing catastrophic trauma exceeded an unimaginably high lifetime insurance cap. After a decade of surgeries and months of physical therapy, he faces a lifetime of constant pain. Once a big donor, he is now dependent on the government.

Like him, millions of New Yorkers are one medical disaster from financial ruin. Under NY Health the cost of healthcare will only rise when your income rises.

Fully employed. Got sick. Lost Job. Lost insurance. Bargained for his life.

Losing his job cost him his insurance. Inability to afford healthcare became a vicious, life-threatening cycle. During the first round of illness, his insurance paid $1500 for treatment. After a relapse — near death — but with no insurance—the same treatment was quoted at $20,000. He negotiated for his life. Big insurers negotiate. The uninsured must beg and hope.

If you're without insurance, you haggle for your life the way you haggle for a car. If you're insured through work, you aren't adequately insured. Period.

Teacher insured by school. Pregnancy complications. No Insurance. Three lives at risk.

A young, healthy, single mother, she was six months pregnant, with three children—one just hospitalized with dangerous depression. A teacher at a private school, she was diagnosed with preeclampsia — and prescribed total bed rest. She lost her job and her very good insurance. Applying for Medicaid turned into a fight for her life, her unborn baby's life, and the life of her at-risk tween. Years later, she remains in healthcare limbo: Medicaid helped save three lives, but Medicaid rules and means testing conflict with getting part-time, per diem, and probationary jobs, the access points to full-time employment with health benefits.

With NY Health, she wouldn't have been so desperately worried about leaving her children orphans, her at-risk tween wouldn't have returned to a family in crisis, and today she wouldn't worry about keeping coverage. She'd be glad to pay more as her income rises.

Cause of death: Age discrimination. Fortune 100 fires chief litigator. Curable cancer kills.

He was fired just before his 60th birthday, having successfully litigated yet another antitrust case before the Supreme Court. He lost his high salary and his health insurance and took COBRA at exorbitant rates. After a few years liquidating his savings, he dropped COBRA, knowing he was healthy and would be on Medicare soon. When he turned 65, a doctor-recommended colonoscopy showed Stage 4 colon cancer. He died within a year, age 66.

By eliminating the financial obstacles to seeing an MD and the age requirements of Medicare, NY Health could have saved his life without leaving him in penury.

Medical student. Experiences "Separate but Equal" healthcare in NYC.

Because she couldn't afford the medical care offered by her NYC teaching hospital, a young resident in her dual role as patient and doctor experienced the legal segregation of our city hospitals. Over 80% of patients on Medicaid identify as Black or Latino, while only 30% of privately insured patients do. Privately insured patients get continuity of care from doctors in better-equipped hospital wings. Medicaid patients see rotations of residents and interns in separate buildings. Skin color signals the disparities of income-based healthcare.

With NY Health, patient income will not determine provider reimbursement level, eliminating tiered service levels — and "separate but equal" in NYC.

These stories are part of a weekly series (since 6/18) where New Yorkers share personal stories about "Healthcare in America," published in This is the Bronx, an online newspaper edited by Gary Axelbank.

Health Story Testimonials in support of Resolution 470 — NYC Council Health Committee
December 6, 2018

Financier. Well insured. Motorcycle hit-and-run. Maxed insurance. Bankruptcy. Medicaid.

My life changed forever on March 31st, 2009: while crossing the street, a speeding motorcycle hit me. The impact sent me flying 25 feet, breaking every bone on my right side, from my clavicle to my toes.

I am grateful to modern medicine to be alive.

The trauma was catastrophic. Seven open fractures to my leg, nine broken ribs piercing my lungs, and a broken clavicle. Many surgeries, some more than 14 hours long, rebuilt the right side of my body.

Months of physical therapy and private nurses followed. I had to learn to walk again, to move my arms up and around, to feed and bathe myself. The vascular trauma to my legs was so extensive I have had 11 surgeries on my left leg, the most recent 8 months ago.

My world became increasingly smaller – a world of doctors, therapists, nurses, aides … and more nurses and more therapists. Where I once found fulfillment in building companies and serving on the boards of numerous organizations, exigency required total focus on caring for wounds and learning basic skills of self care.

Shortly before the accident, my insurance broker arrived with forms to complete. Where I thought we were maximizing coverage, I was actually setting coverage limits. "I'll never need that amount of insurance" was the thinking. Well, I thought I had damn good insurance. But after the first seven-figures, my insurance was capped. Bills continued to arrive–even now. After several more bills reached seven digits, I was forced to file for bankruptcy.

For three decades I'd known myself as a highly regarded professional. I was considered among the best in my field, the subject of two documentaries and a WSJ Column 3 profile. But here I was: bankrupt. I felt shamed. Slowly, I learned that our health care system is so broken that two-thirds of bankruptcies are medical.

During this time, I applied for Long Term Disability. I can now look back and laugh at the experience. But not at the time! As often happens, my first application was denied. I reapplied. The good people at Social Security mean well and are tremendously overworked. But my file was lost – twice. Just before my first court hearing, my attorney was hospitalized with a medical emergency. When my second hearing date arrived, the Judge was called to another court. Finally, the third date arrived, and my file was present, I was present, and the Judge was present. I was awarded Long Term Disability.

Naturally, I thought a check would come. It didn't. After waiting months on end and diligently checking with the Social Security office, the manager of the New York Office called the manager of the Chicago office to request my check be expedited. It was. Six weeks later. The only problem was that the size of the award necessitated that the balance be paid over three installments. Finally, after more than 2 years, my Social Security Disability Check was paid in full.

The Tom I knew for 50 years is no longer. I am still getting to know the new Tom. Some days feel fragile; other feel strong. The New Tom lives with chronic pain. In my prior life, I served on the boards of social service agencies, always helping to raise monies, rarely getting to fully know the services offered or the clients. Today, I am one of those clients, and eternally grateful to such organizations and their funders.

I am active in several support groups that meet to help one another navigate this New Normal. Each of us has a full plate of stressful issues, many to the point of overload.

I've learned a few profound truths in my journey thus far.

- First, life as we know it can turn in an instant, forever and unalterably changed.
- Second, healing takes time, financially, emotionally, physically – leaving us in varied stages of preparedness and awkwardness and clumsiness. It takes time to embrace the new you, the new me.
- Third, we are our brother's keeper – we owe it to ourselves and to one another to be there for each other. Most assuredly this includes healthcare.

Worrying about paying for healthcare should never be an issue on anyone's plate. Healthcare is a moral good, not a for-profit commodity. It should be universal, comprehensive, cost-effective and affordable. This is why I support the New York Health Act.

— Faris M. Thomas, Jr.

http://www.thisisthebronx.info/weekday-magazine-healthcare-in-america-an-ongoing-series-9/

These stories are part of an ongoing series where New Yorkers share personal stories about "Healthcare in America," published weekly in This is the Bronx, an online newspaper edited by Gary Axelbank.

Health Story Testimonials in support of Resolution 470 — NYC Council Health Committee
December 6, 2018

Fully employed. Got sick. Lost Job. Lost insurance. Bargained for his life:

I almost died eleven years ago. Initially, I had a job with insurance, but illness cost me my job. Losing my job cost me my insurance. Not being able to afford healthcare almost killed me. My story is a vicious, like-threatening, cycle. I've learned that hundreds of thousands of Americans have similar stories.

A few years earlier, I had my first episode of biliary duct obstruction and didn't get so sick. My insurance company paid $1,500 for a cholecystectomy and, after weeks of recovery, I was almost back to normal, living my life and doing my job, but now my job didn't include health insurance. Not all jobs do, even some that recruit you with promises of health insurance.

So there I was eleven years ago, working every day, and then I got really sick — intense bloating, jaundice, a fanatical itching that kept me from sleeping for four months. It was constant every hour of every day. Non-stop. I was in such misery. I lost weight. I was hollowed out.

One friend said I looked like a "dead man walking."

The hospital told me it would cost $20,000 for the same treatment they'd charged the insurer $1,500 for a few years earlier. I was dumbfounded. Why was the cost so high for me when I no longer had health insurance? $1,500 would have been difficult, but $20,000 was unimaginable. Without insurance, without $20,000, I wondered if I should just give up and die.

I told the hospital administrator that the grave was beckoning since I didn't have $20,000. Suddenly, the price became $13,800. This was still an unimaginable sum, but I found it inconceivable to be bargaining for my life. Was I in a parallel universe?

I dissociated: from the inside I was scared and miserable; from the outside I couldn't fathom the absurdity. Do others go through this?. Can you imagine bargaining for your life the way you haggle for a used car? It's inhuman to think about putting a price tag on my life—or yours.

I was in constant itching agony and couldn't fathom how $1.5K could become $20K could become $13.8K. Was there any reason for these numbers? I explained again and again that I simply didn't have that much. As I turned yellower and yellower over the weeks, the price finally dropped to $8,000 — I'd negotiated the price of my own life down 65%. Is this free-market healthcare? Is this what they mean by being a savvy healthcare consumer?

I wasn't trying to be a good capitalist or a knowledgeable consumer. I simply wanted to save my life. But I felt demeaned. This experience and others are why I support passage of NY Health — Improved Medicare for All New Yorkers.

Only in the U.S. do healthcare costs lead to financial ruin, bankruptcy, or death. Every other developed country has universal healthcare; everyone is covered, and lack of wealth doesn't prevent care. An estimated 45,000 Americans die each year because financial hurdles prevent life-saving medical care.

Many of these have insurance, but high-dollar deductibles mean they don't get early, treatable, diagnoses. When others, also insured, get seriously ill, pre-authorization delays and benefit denials force them to face ruinous out-of-pocket costs. Many, like me without that much in savings, or not wanting to impoverish their families, forego treatment — and die.

NY Health will remove financial obstacles to care. If you lose your job because of illness, you'll still be able to see a doctor and get treatment.

You won't ever hear that you need to find $20,000 — or $13,800, or $8,000 or even $1,500 — for a now-routine procedure that prevents death. When you have a job, you'll pay a progressive income-based payroll tax. If you lose that job, you won't lose healthcare. Your children won't lose their healthcare; they'll be covered because they're children. Families will worry about loved ones getting better, not about going broke.

— Walter Carpenter

http://www.thisisthebronx.info/weekday-magazine-healthcare-in-america-an-ongoing-series-5/

These stories are part of an ongoing series where New Yorkers share personal stories about "Healthcare in America," published weekly in This is the Bronx, an online newspaper edited by Gary Axelbank.

Health Story Testimonials in support of Resolution 470 — NYC Council Health Committee
December 6, 2018

Single Mother. Insured by employer. Pregnancy complications. Three lives at risk.

Part I: My life explodes into a healthcare nightmare

My healthcare story began 2.5 years ago. I was six months pregnant, with three wonderful kids, and teaching at a private school focused on special needs students when I was diagnosed with preeclampsia and severe ante-natal depression. I was prescribed total bed rest.

Here I was, in a high-risk pregnancy that can lead to HELLP syndrome, a life-threatening complication that had recently almost killed a good friend of mine. I already knew American women can and do die from this; it's part of why the US is the only country with rising maternal mortality. I knew I needed pre-natal medical visits and medical care to save my baby — and to save my own life. The idea of leaving my three older children motherless terrified me.

Rather than giving me a medical leave, which I expected, my school terminated me—which terminated my health insurance, and the health insurance of my children. Catch 22 ensued:

- I wasn't eligible for unemployment because I was supposed to be on complete bedrest and so couldn't look for a job
- I wasn't eligible for disability because it wasn't permanent; high-risk pregnancy is temporary (when not lethal)
- Further, my employer processed my termination in a way that prevented my applying for COBRA
- I was scared, and not just for me.

Yes, I was in the most dangerous trimester of a high-risk pregnancy, but my tween, recently diagnosed with severe emotional disability and suicidal depression, had just been accepted into an in-patient program. When I lost my health insurance, she was terminated from her program. I knew I needed medical attention, but her needs were potentially even more serious, and I had no way to provide her with out-patient help or counseling.

I decided to apply for Medicaid which I ultimately got. But it wasn't easy.... [Grusome details online.]

Let me summarize. I had a job and I had health insurance. Then I got sick and lost my job which terminated health insurance for my entire family — with three of us (one in utero) at high risk of death. We were lucky that I was less naïve about the difficulties of navigating Social Services than I could have been, and that I had resources to jump all the hurdles rapidly.

We were all incredibly fortunate that I didn't fall into such debilitating depression that I couldn't leave my bed, although I came close. Having friends and family makes a difference. In short, as anguishingly horrible as it was, we all survived.

Part II: The nightmare subsides into healthcare limbo

But, just like life, my story continues — not yet as good as it was before the preeclampsia, but so much better than the three months after diagnosis. Getting a teaching job is never easy.

- Needing work, I took per diem substitute jobs which give no benefits — far away in Brooklyn
- I'm a good teacher and those became part-time substitute jobs, which meant a bit more income stability, but still no benefits.
- Finally, I got a leave replacement, which offered benefits but my salary was still low enough to qualify for Medicaid, so I refused the $400/month premiums.
- Last year, I got a part-time substitute offer at a school much closer to my home, and faced the same pay challenges — which meant I remained eligible for Medicaid.
- This job finally turned into a leave replacement last spring and, again, I had to refuse the offered healthcare benefits because there was no guarantee that the job would last more than four months. I kept Medicaid because my children need healthcare — they are active, interested kids, have accidents, need immunizations, and sometimes even get sick. My 'tween is stable but, as a parent, I don't want my insecure employment benefits to harm any of my children.

I live in a state of uncertainty about both employment and healthcare — but I am optimistic. To make myself even more attractive — I am working on additional certification so my school can use me in a greater variety of subjects in classrooms with a greater variety of students.

NY Health would have guaranteed that losing my job would not have meant losing healthcare. After my termination, I surely would have thought about getting my next job, but I would not have been so desperately worried about leaving my children orphans. And my daughter could have continued the excellent program she'd entered rather than interrupting it to return to a family in crisis with a mother who was almost as depressed as she was.

With NY Health, I wouldn't today be so consumed with figuring out how to continue coverage with as few gaps as possible. Under NY Health I'll be happy to pay more when my income rises.

— Carmen Lyra

http://www.thisisthebronx.info/weekday-magazine-healthcare-in-america-an-ongoing-series-13/

These stories are part of an ongoing series where New Yorkers share personal stories about "Healthcare in America," published weekly in This is the Bronx, an online newspaper edited by Gary Axelbank.

Health Story Testimonials in support of Resolution 470 — NYC Council Health Committee
December 6, 2018

Cause of death: Age discrimination. Fortune 100 fires chief litigator. Curable cancer kills.

I miss my brother. A brilliant trial lawyer, working in the General Counsel's office of a Fortune 100 company, Johnny was abruptly fired just before he turned sixty.

I am, of course, biased about this tragic turn of events; just let me say that Johnny had argued (and prevailed) for his company multiple times before the Supreme Court (and many US Courts of Appeals); indeed, the company waited until after yet another lucrative win before terminating him by phone. I took satisfaction in the company's judicial fortunes suffering after he left, not to mention the firing of his boss.

He took COBRA. It was jaw-droppingly expensive. He looked for a new job. Age discrimination is real. Prospective employers explained they couldn't pay him what he was worth and they knew he'd jump ship if they offered what they could afford.

Never mind that NYC is too expensive to be jobless and still pay for housing. Johnny cut back on expenses, began spending his savings, took Social Security early — and then, after getting a physical, dropped his health insurance.

He figured he'd be on Medicare within 3 years. He rationalized that he'd often gone years without a physical. "Nothing bad happened then; nothing bad will happen now. And COBRA is eating my retirement money."

He began having digestion issues, but put off seeing a doctor because he couldn't afford anything expensive — and "Medicare will kick in soon, and cover whatever they find — and, more likely, whatever they don't find — doing loads of expensive tests."

Then he turned 65 and got his Medicare card. His physician had retired, so finding a new one took time. He called after the appointment to complain that the new guy was insisting on a colonoscopy, "which sounds nasty." We argued. He made the appointment.

After the colonoscopy, we argued again. The GI doctor wanted to schedule immediate surgery. "Surgery! Hell, no!" I met him a few days later in the lobby of NY Presbyterian, "5 am! Hell, no!" I kept him company for the hour of pre-surgery waiting, and hung out in the family lounge — wondering why a 45-minute procedure was taking 2+ hours.

Then his surgeon arrived, looking sad. He'd removed a "mass the size of a large lemon." Johnny had Stage IV colon cancer. He needed chemo immediately but the surgery had been so invasive he also needed to heal from the surgery. Multiple doctors built a plan. Johnny was scared and said he would do "whatever it takes."

Eight months later, after many rounds of chemo, which his oncologist kept saying he'd "failed," Johnny became depressed: it was his "fault" he wasn't better. Johnny, who'd aced every test he'd ever taken, finally came to live with me because he'd failed. I got his company and wit and insight, while he got food, and caring. Johnny died a year after that physical. And, no, not because he'd "failed."

He shouldn't have died. Had Johnny's colon cancer been diagnosed by a colonoscopy at Stage 0 or 1, he'd surely be alive today. Even if he'd been diagnosed at Stage 2 or 3, he might well be alive: Stage 3A has a 5-year survival rate of almost 90%.

I miss my brother Johnny. I know he shouldn't have gone three years without seeing a doctor. I also know he could not have been afforded all the treatment he got without health insurance.

No one should die because seeing a doctor could lead to bankruptcy. Medicare, even with its gaps and flaws, is a godsend for those who live to enjoy the years it adds to their lives.

We all need "Improved Medicare for All New Yorkers," NY Health, which will save us money, cover us all — and keep brothers like Johnny alive and thriving decades longer.

— Johanna Bard

http://www.thisisthebronx.info/weekday-magazine-healthcare-in-america-an-ongoing-series-12/

These stories are part of an ongoing series where New Yorkers share personal stories about "Healthcare in America," published weekly in This is the Bronx, an online newspaper edited by Gary Axelbank.

Health Story Testimonials in support of Resolution 470 — NYC Council Health Committee
December 6, 2018

Medical student. Experiences "Separate but Equal" healthcare in NYC.

I am a medical student in New York City and I am 24 years old. I went into medicine out of an overwhelming desire to help others, particularly those who are most vulnerable.

Navigating our complex healthcare system has shown me that it often fails those who need it most. Even for those with health insurance, access and cost remain problematic — as I have seen as both a future physician and as a patient.

At the NYC teaching hospital where I work, there are actually separate buildings for patients with private (for profit) and public (Medicaid and Medicare) health insurance. Patients with private insurance are seen by faculty members, while those with public insurance are seen by a rotating cast of residents (doctors in training). Those without health insurance aren't seen at all — unless they go to the student-run clinic, where medical students practiced on them.

The hospital claims that patients on public and private insurance receive comparable care, but as history has shown us, "separate but equal" is not equal. Patients at the public clinic have longer wait times for appointments, and their doctors change every few years as residents graduate and new doctors in training take over. Such constant rotation prevents patients from getting the continuity of care required for quality healthcare interventions.

Despite the widespread use of electronic medical records, busy doctors often can't take the time to read through the entirety of a patient's chart.

Patients who consistently see the same doctor have a distinct advantage over those who don't, who see a new rotation of physicians each time they are treated or hospitalized.

Inconsistency increases the odds that long-standing conditions are overlooked or ignored, often the difference between life and death. Medicine relies on resident labor as a teaching tool, but this segregated system skews the distribution of resources so that those who are privately insured receive care by the most senior physicians, while those who are on Medicaid and Medicare receive a disproportionate amount of their care from doctors who are still in training, with fewer skills and less experience.

Data demonstrates this system creates *de facto* racial segregation. In NYC, over 80% of patients on Medicaid identify as Black or Latino, while only 30% of privately insured patients do. In practice, this means I can guess whether a patient will receive the higher level of care at the private clinic just by looking at the color of his/her skin.

Unfortunately, such disparities extend to nearly every aspect of our hospital and medical school. On the OB/GYN service, patients with public insurance are seen on a different floor with fewer amenities than the privately insured patients. Newborns at the hospital are separated according to insurance status, ensuring that these healthcare inequities are present from each baby's first breath. At the medical school, it's well known that a rotation at the public city hospital means "getting to do more" and having more autonomy when practicing on patients.

When I tried to make my own appointments, I had a hard time finding physicians at the hospital who accept Medicaid.

Although I live less than 5 minutes away, I knew that being a Medicaid patient there meant receiving lower quality of care, and I decided to seek care at a clinic that serves everyone, regardless of insurance status. I am fortunate to be in good health and to have the tools and resources to make informed decisions about my own healthcare, but I worry that many of my most vulnerable patients do not. This unequal system penalizes low-income patients and delivers substandard care to people who desperately need quality medical attention from skilled diagnosticians.

Worst of all, this segregation is entirely legal. Because it is based on health insurance status, not race, hospitals throughout the city continue to segregate patients to achieve purported "cost savings." While this system has dubious financial benefits, it has very real health consequences.

Our medical school teaches us to value every human life, to treat all patients as equals and care for them with dignity, compassion, and the highest clinical standards; but this system runs contrary to everything we've been taught, undermining it.

This multi-tiered, income-based system isn't fair. It's not fair to patients — or to medical students, who need healthcare to become doctors and who need quality supervision to do the right by their current (and future) patients. Nor is it fair to doctors who I see trying to give each patient their full attention and best care — regardless of having their fees determined by their patients' income.

We need to level the playing field on healthcare — for patients and for providers. NY Health will make a difference.

— Serena Castile

http://www.thisisthebronx.info/weekday-magazine-healthcare-in-america-an-ongoing-series-10/

These stories are part of an ongoing series where New Yorkers share personal stories on healthcare in America, published weekly in This is the Bronx, an online newspaper edited by Gary Axelbank

New York State Assembly Health Committee

Hearing on Support for New York State Health Bill A4738 A/S 4840A

December 6th, 2018

Good morning. My name is Priscilla Bassett and I am a longtime member and former officer of New York StateWide Senior Action Council and retired co-Chair of SLAC, the Senior Legislative Action Committee of Sullivan County. Both are grassroots organizations dedicated to supporting the security and quality of life of seniors through education and advocacy. We have long supported previous bills intending to establish universal health insurance on the federal and state level. For identification purposes I am also a member of the DC 37 Retirees Association, having worked for the New York Public Library until my retirement. I now live part of the year here in Manhattan.

You might ask why seniors, already beneficiaries of Medicare, would direct their energies toward the passage of the New York Health bill? Why would I, a 25 year beneficiary of traditional Medicare, be here before you today? Part of the answer is very simple. In my childhood there was an elegant automobile, the Packard car, Its slogan was, "Ask the man who owns one". We seniors know from personal experience the sense of

security, guaranteed access, and simplicity of billing that Medicare offers. Universal health insurance works for seniors and would work for everyone.

This is not to say that Medicare, as currently constructed, is without its shortcomings. The untoward effects of partial privatization are apparent with Medicare Part D, the pharmaceutical insurance component, a gift to the already immensely profitable health insurance industry. The introduction of Medicare Advantage plans in the Medicare Modernization Act of 2004 brought profit making and its attendant undermining of original Medicare. Hearing aids, dentures, and eyeglasses are not covered by Medicare. These are important accoutrements of aging as we strive to maintain our health and quality of life. Long-term care is extremely limited under Medicare as currently structured and leaves most seniors dependent on Medicaid if coverage fails. These benefits, we are glad to learn, would be covered under the New York Health Bill; such welcomed improvements would be provided for everyone.

Significantly, the New York Health Bill will eliminate deductibles and out of pocket costs. People enrolled in Medicare pay a significant amount in cost-sharing or for premiums for supplemental insurance to control out of pocket costs. In 2016 they paid 14% of household expenses toward health care costs, more than double that of non-Medicare households (6%.)

Others who testify today will analyze the savings that universal single payer coverage would bring. These are important arguments to consider. We - SLAC - provided such background to our county legislators and I am proud to say that the bipartisan Sullivan County legislature has unanimously endorsed the New York Health bill.

I am truly honored to be speaking to the City Council as part of such a distinguished speakers list. Other seniors here today include StateWide Senior Action Council of New York City members.

Seniors bring a unique perspective to universal health insurance because we are living examples of the benefits of a single payer-system. Seniors all have friends, family, neighbors who don't have this protection. We are proud to support the New State Health Bill, which will provide improved Medicare for All for New York State. It is not only a good idea - a moral commitment to Health Care as a Human Right - it is a cost effective program that will WORK! Please pass City Council Resolution 470 on behalf of my fellow New York City constituents - cradle to grave!

Thank you. Priscilla T. Bassett

FOR THE RECORD

New York Health Act Testimony

Carol J. Clouse

Brooklyn, NY

My family's story is not dramatic, like many stories about healthcare in this country, but our situation is quite common and becoming more so every day.

The freelance workforce in the United States is growing three times faster than the traditional workforce, according to the 2017 Freelancing in America Survey. If this growth continues at its current rate, more than half of US workers will do some form of freelance or gig work by 2027.

My husband and I are part of this growing number of Americans. I'm a freelance writer/editor; he's business technology consultant who works on a project basis. We have one child, who's eight years old.

Two years ago, my husband was laid off from his job at IBM, and since then our healthcare situation has been tenuous.

When he worked for IBM as a salaried employee, we had a good employer-sponsored (silver) plan with Empire Blue Cross/Blue Shield. I've always chosen the silver option—not the best plan with the highest premiums, but not the cheapest plan with the worst coverage. Something in the middle.

When the company laid him off—as part of a general restructuring—my husband was working on a project for the US Department of Interior. The project still needed him, so the project manager helped my husband secure a position with one of IBM's subcontractors. The job paid by the hour, not a salary, but luckily it still came with employer-sponsored healthcare coverage—a decent plan with Aetna, though not as good as our previous one.

Problems began, though, just a few months after the subcontractor hired my husband, when President Trump announced widespread federal budget cuts. My husband didn't get laid off again, but the DOI slashed the budget for the project, and his hours were slashed along with it. So he had to find additional work.

A lot of the type of work my husband does is contract work. He did find another job, but it's a contracted, hourly position with no benefits.

So now, he works two jobs: one full-time as a contractor with no benefits, and one part-time with the IBM subcontractor because, weirdly enough, we still have health insurance through them despite my husband's part-time status. We "have" it, but we could lose it any minute—either because the DOI decides to kill the project, and the subcontractor doesn't have more work for him; or because the subcontractor simply decides they can't afford to offer us healthcare anymore. In fact, at the end of 2017, we thought for sure we were going to lose our coverage. It's a small company, and they sent out a letter saying that, with the cost increase for the coming year, they could no longer afford what Aetna was offering. In the end, though, they found a cheaper alternative.

Our current plan, our third in roughly two years, is through UnitedHealthcare. It's a silver plan and costs us more than $1,200 a month in premiums for the three of us. And it's pretty terrible. The deductibles and co-pays are high compared to our previous plans. For example, I take two medications, and those two prescriptions cost me $165 a month. With our previous Aetna plan, I paid a total of $35.

Moreover, for all the money we pay, we get zero security. We never know if we'll still have this coverage next year or next month, making healthcare a constant source of anxiety. At times, we've toyed with the idea of just buying our own coverage on the NY Marketplace. The problem is the family plans on the marketplace are incredibly expensive and go up significantly every year. (Not to mention that the price for a family plan is the same whether you have one kid or ten. Which helps families who have multiple children, but doesn't do much for those of us who only have one or two.)

The cheapest silver family plan for 2019 is HealthFirst at $1,656 per month. But the doctors we go to now don't take this plan, which makes me wonder how many providers do. Prices then increase, all the way $3,000, with UnitedHealthcare. We can't afford to pay $2,000 to $3,000 a month for health insurance. That's like having a second mortgage or paying rent on two apartments.

Still, I know we're actually pretty lucky. Over the last two years our coverage has gotten progressively worse as our costs have increased, and the insecurity is stressful. But compared to many of the stories you hear about healthcare in this country, people being denied treatment or going into bankruptcy, our story is actually one of better ones.

How sad is that?

In closing, I'd just like to say: We understand implementing a single-payer system will be difficult. We understand our taxes will go up, and there will be a lot to complain about in the beginning. However, my family is willing to pay that price to have healthcare coverage we can depend on. Because people's healthcare shouldn't be at the mercy of corporations that can and will lay you off when they feel they need to. Because people who don't work for a company that subsidizes their health insurance shouldn't have to pay so much more for their healthcare than people who do. And because if all of the corporations, businesses and families in New York pay their fair share in taxes, I cannot imagine that my family will pay more in additional taxes than the roughly $25,000, and counting, we've paid this year in insurance premiums, deductibles, co-pays, etc.

With costs skyrocketing, and the options on the healthcare marketplaces declining, what exactly are we as a nation going to do when more than half the people in this country are freelancers without employer-sponsored healthcare? The gig economy is here. We need to address the healthcare crisis now before spins even further out of control. We need a system that's affordable, permanent and equitable. We need a single-payer system, and New York should lead the way by passing the New York Health Act.

FOR THE RECO

Good afternoon. My name is Constancia Dinky Romilly. I am an advanced practice nurse, co-founder of the Pain Management service at Bellevue Hospital Center, now retired.

First, I want to express my bewilderment at the very idea of the insurance construct applying to health care. Let's bring some common sense into the picture; Insurance is something one obtains in the eventuality, hopefully never experienced, of a catastrophic event occurring, such as an auto accident or fire in one's home.

Health care, to the contrary, is an expected fact of life. As residents of NY State, we should expect that our health care would be seen in the same light as other aspects of our daily lives. We cover these together through one kind of tax or another: schools, roads, police & fire protection, sanitation, as a few examples. Let's apply common sense to paying for health care.

As an advance practice nurse working in the public sector, I saw the best in the public payment systems - Medicare and Medicaid. For the most part we were able to provide our complex patients with the whole range of interventions our multidisciplinary team proposed after extensive investigation of the pain issues presented. In those cases where the patient was so-called "self-insured", or sometimes in Medicare Managed Care plans, I saw the worst face of the mis-named insurance system. Hours spent on the phone, often with insurance company clerks whose job it was to deny the prescribed care. More hours duplicating explanatory letters, imaging studies, patient history to "justify" to the nay-saying company employee. This is madness and the solution is at hand.

Please pass Resolution #470 in support of the NY Health Act, for all New Yorkers.

Thank you.

Constancia Dinky Romilly, RN, MS
39 E. 7th Street, Apt. 1
New York, NY 10003
cdromilly@gmail.com
917 991 5653

FPWA

Fulfilling the promise of opportunity

Testimony prepared for the New York City Council's
Committee on Health

Hon. Mark Levine, Chair

Prepared By:

Aswini Periyasamy
Policy Analyst

Submitted By:

Jennifer Jones Austin
Executive Director/CEO

Federation of Protestant Welfare Agencies, Inc.
40 Broad Street, 5th Floor
New York, New York 10004
Phone: (212) 777-4800
Fax: (212) 414-1328

My name is Aswini Periyasamy and I am the Health Policy Analyst at FPWA (the Federation of Protestant Welfare Agencies). I want to start by thanking the Committees on Health for the opportunity to testify before you today and for your leadership on resolution 470 and the issue of single payer health care in New York, a topic that deeply impacts our city, state, and nation overall. We deeply support the advancement of this resolution to a vote as soon as possible to make a clear statement of New York City's deep commitment to quality, affordable, and comprehensive health care for all New Yorkers.

FPWA is an anti-poverty, policy, and advocacy nonprofit with a membership network of nearly 170 human service and faith-based organizations. FPWA has been a prominent force in New York City's social services system for over 95 years, advocating for fair public policies, collaborating with partner agencies, and growing its community-based membership and coalition networks to meet the needs of all New Yorkers. Each year, through our network of member agencies, FPWA reaches close to 1.5 million New Yorkers of all ages, ethnicities, and denominations.

FPWA is also a steering committee member of the New York Caring Majority, a statewide coalition of seniors, people with disabilities, family caregivers, domestic workers, and home care workers. The NY Caring Majority's goals include organizing together to support long-term care workforce development, as well as to defend and strengthen our healthcare system to make it affordable and accessible for all in need.

We at FPWA, along with our member agencies, believe that true economic equity can only be realized through a system that eliminates the disparities that create and perpetuate poverty while equipping and empowering people to sustain themselves, their families and their communities. To that end, we work deeply with our member agencies on creating policy change that address the factors that contribute to economic inequity. This includes addressing health disparities among vulnerable populations, targeting the drivers that feed into the continuation of epidemics like HIV/AIDS, and promoting access to public programs that can improve population health.

We are currently in the middle of the 2019 open enrollment period for the New York State marketplace. The expansions in access to health care the Affordable Care Act has ushered in brought health coverage to millions who could not otherwise access the care they need to live their lives.

But this access has not created the coverage we need to truly realize true universal and comprehensive health coverage. For those who do not qualify for Medicaid or the Essential Plan, they must often rely on Marketplace coverage with high deductibles and premiums, or on employer-based coverage that similarly does not cover their needs. Current health care systems are not equitably accessible to low-income people, people of color, people in need of long-term care, and immigrants – causing disparate health outcomes as a result. Discrimination targeted at immigrants, communities of color, and LGBTQ clients also create inequity in health outcomes. For instance, at least 402,000 immigrant New Yorkers statewide currently lack health insurance – and are not eligible for Medicaid or Essential Plan coverage.

Older adults face particular health challenges. There are 3.2 million people 65 and older in New York State, and 1.2 million in NYC—and this number is rapidly increasing. A national study has shown that seven out of ten people over the age of 65 will require some form of long-term care support. However, in New York, the average cost for a private room in a nursing home is $140,416, the cost for an around-the-clock aide is more than $100,000, and the cost for an adult day healthcare center is $20,800. These costs are not covered under Medicare. Because the cost of long-term care in New York is astronomical, most New Yorkers cannot afford to privately pay for long-term care services and supports for very long, even those who have enough income that they do not qualify for Medicaid. The Expanded In-home Services for the Elderly Program provides some funding for homecare, but it scratches the surface of the need. Currently, there are over 1,000 people on

waitlists. Moreover, the program only allows a maximum of 20 hours a week for home care, and due to inadequate funding most recipients get fewer hours than they need.

As a result, caregiving often falls to family members and loved ones; and it takes a financial and emotional toll, especially as there are very few public supports for caregivers. Most caregivers are women, typically older themselves, and many have to take time off work to provide this care. This results in lost compensation through salary, promotions, pensions, and social security earnings.
This lack of funding and support for those living with long term care needs, or the workers and unpaid caregivers who support these individuals, is an equity issue that must be addressed.

Between threats to the Affordable Care Act, proposed changes to public charge, and threats to LGBTQ and other marginalized populations, the last few years have seen numerous attacks on our public programs and the communities who use them. The federal government has increasingly utilized rhetoric, and later policy, laced with xenophobia that villainized poverty and programs that promote health equity for all.

In a time where health is so uncertain on every level of the American governmental system, we believe New York City must reduce health disparities by ensuring that all New Yorkers have equitable access to universal, affordable, and comprehensive health care coverage. New York has shown such leadership with the expansion of Medicaid and continuing funding for navigator and outreach programs that help vulnerable populations know their rights to health care.

Many employers do not often have the funds to negotiate and provide quality coverage to their employees. Meanwhile, health care costs are growing faster than workers' wages. Research has shown that nearly a quarter of all working-age adults with job-based coverage have such high out-of-pocket costs and deductibles that they are effectively underinsured. This puts many communities, including those individuals and families who have inadequate health coverage, in the position of putting their limited incomes towards health care or towards other essential needs, such as housing, food, transportation, and education.

For nonprofits operating on often minimal budgets, this has an additional impact: the resources they can allocate towards employee coverage doesn't guarantee the full coverage their employees need. Over 40% of our member agencies highlight health care as one of the top challenges to achieving economic equity in New York City.

There is a solution - the passage of the New York Health Act (NYHA), which would bring single payer health care access for New York State. This would provide universal comprehensive health coverage for every New Yorker. Using a progressive tax model based on ability to pay, NYHA would cover more clients and provide more medically-necessary services. This taxation would not represent billions in entirely new funding needed to run New York Health – rather, this replaces the billions private insurance premiums, out-of-pocket spending, Medicare Part B premiums, and local Medicaid costs for inequitable access to health services and coverage.

Through the New York Health Act, New York state would cover many more people who don't have insurance as well as those who are underinsured, covers more services than are currently covered under our health insurance landscape, and helps streamline many of the inefficiencies that plague the process of actually providing care. With no administrative or health care provider costs associated with insurance, New York Health Act would save billions and promote a more equitable New York.

As an anti-poverty nonprofit representing human services providers citywide, FPWA sees single payer as a way of promoting a stronger, more equitable New York. We would be able to cover those who do not currently have health coverage at a lower cost, while also eliminating the inequitable health access people with coverage

currently receive. New York Health Act would have the added benefit of creating savings service providers could use to provide better coverage for their employees and more services to their clients. The savings individuals receive, in the meantime, could be used towards other resources they need to maintain health and wellbeing – safe, affordable housing, quality education, nutritious food, and more. Health equity is achievable – and health can be a human norm right here in New York.

Moreover, any new health care system that fails to incorporate a robust and comprehensive approach to long-term care will ultimately leave families behind. To that end, we support a long-term care benefit that places a value on services and supports to enable aging adults and people with disabilities to access the full scope of care. With this addition, the New York Health Act would guarantee caregivers have adequate health care to take care of themselves, and with a long-term benefit it would mitigate the effects of caregiving on their incomes and careers.

The New York City Council has shown tremendous leadership in health and health equity, especially in a time where healthcare access is constantly under threat. FPWA has been fortunate to work with the New York City Council on one important initiative, Access Health NYC. Formed in response to New York City's high number of uninsured residents, Access Health NYC targets individuals and families who are uninsured, LGBTQ, formerly incarcerated, homeless, have limited English proficiency, have disabilities, live with HIV/AIDS, and are experiencing other barriers to health care access or are missing information about health coverage and options. We were thrilled to work with over 30 partner organizations and the New York City Council to secure further funding this year – this ensured that Access Health NYC providers can reach more New Yorkers in need of health care. However, with the constant turmoil surrounding immigration, budget, and public health policy, many New Yorkers feel even more unsafe or confused accessing or navigating the current health system.

FPWA has been proud to work with our coalition partners at the Campaign for New York Health and the New York Caring Majority and with Speaker Johnson, Chairman Levine, and the New York City Council on this resolution – and we were grateful to see its introduction in August by Speaker Johnson. We see this resolution as a critical opportunity to educate New Yorkers on their right to health – and to show this city's great commitment to health equity and support for single payer statewide. We truly could be the first state to achieve single payer in America. We can and must take this opportunity to strengthen New York City and to show our commitment to health care for everyone. It is critical to New York City's continued growth that residents know that no matter who they are or what their background is – their health and wellbeing is something their city will protect. We can make a strong statement on New York City's commitment to comprehensive, affordable, and accessible healthcare access for all – through the passage of Resolution 470.

Again, we thank the City Council for the opportunity to testify on this powerful issue. We urge everyone to learn more about New York Health Act and we urge the Council to pass resolution 470 in support of this bill. . We look forward to the continued opportunity to work with the Council and with partners here and around the state to ensure everyone have the chance to live healthier lives.

CID-NY

Manhattan
841 Broadway
Suite 301
New York, NY 10003
212/674-2300 Tel
212/254-5953 Fax
646/350-2681 VP

Queens
80-02 Kew Gardens Rd
Suite 107
Kew Gardens, NY 11415
646/442-1520 Tel
718/886-0428 Fax
866/948-1064 VP

www.CIDNY.org

Center for Independence of the Disabled, NY

Testimony to the New York City Council Committee on Health

On Resolution 470 calling on the State Legislature to pass and the Governor to sign A.4738-A/S.4840-A, legislation that would establish the New York Health program, a universal single payer health plan for all New York State residents.

December 6, 2018

Testimony By:
Heidi Siegfried, Esq.
Director of Health Policy
Center for Independence of the Disabled

This testimony is submitted on behalf of Center for Independence of the Disabled, New York (CIDNY), a non-profit organization founded in 1978. CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to full participation in the community. CIDNY helps consumers understand, enroll in and use private and public health programs and access the care they need. We appreciate the opportunity to share with you our thoughts about the New York Health Act and some of our recommendations.

According to the American Community Survey 11.5% of New Yorkers have a disability with 2.1% having a visual disability, 2.7% having a hearing disability, 6.7% having an ambulatory disability, 4.6% having a cognitive disability, 2.7% having a self-care disability, and 5.4% having an independent living disability.

New Yorkers with disabilities are more likely to have health coverage than people without disabilities (94.7 % compared to 91%). They are more likely to use public coverage – Medicare and Medicaid – than people without disabilities (24.1 % and 54.1% compared to 1.7% and 18.9%).

People with disabilities have a right to a transparent, accountable health care system that provides accessible coverage including benefits and services based on medical necessity. The current disjointed system of Medicare, Medicaid, private commercial coverage and other specialized programs is difficult to navigate and often fails people with disabilities.

Free Choice of Providers

CIDNY's Health Policy Director together with other health advocates conducted listening session/focus groups with people around the state regarding their ability to make their health plan networks work for them. Among the problems consumers encountered were difficulty in finding in-network providers that were taking new patients, obtaining timely appointments, communicating with providers, finding providers that are culturally and medically competent to serve patients from diverse backgrounds, getting transportation to their providers, and sudden changes in networks. Participants described numerous situations when they did not receive the care they needed when they needed it. A system in which health care consumers have the free choice of any participating provider with a separate care coordination service to assist members in managing, referring to, locating, coordinating and monitoring health care services to assure that all medically necessary health care services are made available and effectively used in a timely manner could go a long way to improving this situation.

People with disabilities have difficulty finding providers with offices and facilities that are accessible and that have accessible diagnostic and medical equipment. They also have difficulty finding providers that understand their responsibilities under the Americans with Disabilities Act to accommodate any disabilities they might have. Program Standards and Requirements for health care provider accessibility for people with disabilities and people with limited ability to speak or understand English and for cultural competence should be robust and should require training for providers. The

Commissioner should adopt the United States Access Board standards for medical diagnostic equipment.

Of particular interest to people with disabilities are the following:

Long Term Care
CIDNY looks forward to the inclusion of long term care in the New York Health Act including sufficiently funded home care that enables people to maintain their independence in the community. The present system for providing long term care using Medicaid Managed Long Term Care Plans has broken down as most plans have cut back on hours they offer enrollees. Plans that do offer adequate hours to enrollees are going out of business because the capitated rate provided to them does not cover the cost of the level of care their consumers require.

Advocates have sought adequate high needs community rate cells for years to no avail. The suggestion that risk adjustment could be used to address this issue has not been fruitful. Instead the state has proposed that they be allowed to exclude from MLTC plans adult dual eligibles who are "permanently placed" in a nursing home for three months or more. This proposal creates a substantial financial incentive for MLTC plans to unload costly high service need members by moving them from the community to nursing facilities.

A New York Health Act that allows free choice of care coordination as a separate service, eliminates the managed care capitated rate structure, and is adequately funded will help people with disabilities avoid unnecessary institutionalization.

Waiver services

The New York Health Act provides coverage for all health care services currently required to be covered under a number of current health care programs including Medicaid, but it is not clear that Medicaid waiver services would be included.

The OPWDD Home and Community-Based Services (HCBS) Waiver operated by the Office for People With Developmental Disabilities (OPWDD) is a program of supports and services that enables adults and children with developmental disabilities to live in the community as an alternative to Intermediate Care Facilities (ICFs). OPWDD administers this HCBS Waiver. It is OPWDD's primary funding mechanism for supporting individuals in the community by providing a variety of services and supports that are uniquely tailored and individualized to meet each person's needs. These services can include habilitation services, respite care, service coordination, and adaptive technologies. Services are provided either by OPWDD's Developmental Disabilities Services Office (DDSO) staff or through voluntary not-for-profit agencies who have been authorized to provide HCBS waiver services by OPWDD or the NYS Department of Health (DOH).

Similarly, the Nursing Home Transition and Diversion (NHTD) Medicaid Waiver is a Home and Community Based Services (HCBS) program, administered by the New York State Department of Health (DOH) through contractual agreements with Regional Resource Development Centers (RRDC) and Quality Management Specialists (QMS).

The RRDC employs the Regional Resource Development Specialist (RRDS) and Nurse Evaluator (NE), who serve specific counties throughout the State. The NHTD waiver uses Medicaid funding to provide supports and services to assist individuals with disabilities and seniors toward successful inclusion in the community. Waiver participants may come from a nursing facility or other institution (transition), or choose to participate in the waiver to prevent institutionalization (diversion).

Waiver services may be considered when informal supports, local, State and federally funded services and Medicaid State Plan services are not sufficient to assure the health and welfare of the individual in the community, or when waiver services are a more efficient use of Medicaid funds.

CIDNY recommends that both of these programs be continued as part of the New York Health program.

Durable Medical Equipment

People with disabilities will be looking for a benefit package that includes durable medical equipment that meets their needs. Guidelines and practices that were carefully developed for fee-for-service Medicaid to enable access to complex rehabilitation equipment for those who need it are not available to people getting care through a Medicaid Managed Care Plan. Individuals with complex needs and chronic disabling conditions cannot remain mobile, safe and healthy without equipment that addresses their specific disability. They need access to suppliers who have at least one storefront in New York State, have certified technicians on staff and that are able to service and repair the complex rehabilitation equipment.

When CIDNY's benefit counselors help people enroll in an MLTC, they have a difficult time getting the information they need from the Plan about how complex rehabilitation equipment is secured. We ask what the procedures are for getting complex rehabilitation equipment assessed and fitted. We ask if they work with a specific wheelchair seating clinic. If not, do they have their own pt/ot team who will work with their vendor to evaluate and fit the consumer? Plans are unable to answer these questions.

Patients with complex medical conditions and with disabilities rely upon mobility devices not only to stay in the community, but also to prevent pressure sores, facilitate breathing, and relieve joint pain. A CIDNY Consumer, who has traveled to Albany twice to visit legislators, requires a wheelchair with a tilt feature that she must use every hour to avoid skin breakdown. When her chair was being repaired, she could not get it back for 9 months, her condition deteriorated, and a wound care nurse had to be sent to her home.

CIDNY recommends that durable medical equipment provided under the New York Health program include complex rehabilitation equipment that is secured through suppliers with at least one storefront in New York State, have certified technicians on staff and that are able to service and repair the complex rehabilitation equipment.

Physical Therapy, Occupational Therapy, and Speech Therapy

People with disabilities who require physical therapy, occupational therapy, or speech therapy encounter visit limits in Medicaid and commercial plans. Medicare has a dollar threshold.

CIDNY's consumers were dismayed to learn of the adoption of a Medicaid Design Team proposal to place an arbitrary limit on Physical Therapy, Occupational Therapy, and Speech Therapy in Medicaid. For five years our consumers have traveled to Albany to tell legislators that arbitrary visit limits do not make sense and discriminate against people with disabilities. One of our consumers decided not to even begin physical therapy for a hand condition because she knew that 20 visits would not begin to treat it. Another consumer had her neck lock shortly after her PT visits were discontinued. A consumer with osteoarthritis of the spine back and knees told us that her physical therapy is often over in March or April and that she then has to try to manage for 8 months or so with massage or whatever she can put together.

Any misguided attempt to seek savings at the expense of individuals' ability to avoid pain, recover from surgery, and prevent physical decline will harm enrollees. It can result in the need for more expensive treatments like surgery and prescription medications that do not have arbitrary limits. The New York Health program should base all services on medical necessity so that health care consumers can participate fully in daily life, maintain their health and independence.

New York Health Board members

To ensure that the needs of people with disabilities and other health care consumers are adequately met, CIDNY suggests that the 40 member New York Health Board should have more than six that are designated representatives of consumer advocacy organizations. The consumer advocacy organizations should be representative of the various health care constituencies and should specifically include representatives of health disparities populations.

Thank you for consideration of our comments and recommendations. For further information, please contact Heidi Siegfried, CIDNY's Health Policy Director, at 646.442.4147 or hsiegfried@cidny.org.

City Council Resolution # 0470-2018
New York State Health Act
Committee on Health
Councilmember Mark Levine, Chair
December 6, 2018

My name is Bobbie Sackman. I am an advocate working with the statewide NY Caring Majority Coalition, spearheaded by Jews for Racial and Economic Justice (JFREJ) in NYC. The platform of the coalition is to successfully implement universal long term care in NY state through the New York Health Act (NYHA), also known as the single payer bill. On behalf of the coalition, we applaud the Chair, Councilmember Mark Levine and the Health Committee members for holding this hearing on Resolution 0470-2018, "calling on the State Legislature to pass and the Governor to sign A.4738-A/S.4840-A, legislation that would establish the New York Health program, a universal single payer health plan for all New York State residents." ***This is an issue of age justice*** – providing services that allow older adults to live independently and with dignity, for real. This would be a huge exhale among millions of New Yorkers statewide.

We are pleased that 32 Councilmembers, to date, have signed on and trust that this resolution will win strong support from all City Councilmembers as single payer with the inclusion of universal long term care is long overdue. Affordable health care was the prominent issue in the November elections. As the groundswell of support for single payer grows amongst New Yorkers, this resolution is both important and timely. We ask that all Councilmembers approve this resolution and, importantly, discuss support for the single payer bill with their state legislative colleagues.

The purpose of the Caring Majority Coalition at its core is basic – "All New Yorkers should receive the care they need, when they need it so they can live full and independent lives." Yet, this is far from the reality older New Yorkers, people with disabilities, family caregivers, home care workers and others in the care workforce have lived with for many years. We all know this from both our personal and professional life experiences.

Enactment of the NYHA including universal long term care is a woman's issue, age justice issue, workforce issue, immigrant issue and equity issue – that's why we are, indeed, the caring majority, with a stake in what happens.

It is time to build a long term care system based on need, not income. Medicaid and the Expanded In-home Services for the Elderly Program (EISEP) programs are essential lifelines for those who cannot afford the home care they need and other supportive services. The NYHA will include universal long term care from day one.

As the Director of Public Policy at LiveOn NY for 28 years, myself, thousands of seniors, and colleagues have come to the City Council for decades advocating for additional funding for case management and home care waiting lists – this is the EISEP program administered by the NYC Department for the Aging (DFTA). They will come again in the next budget cycle. Under both the Bloomberg and de Blasio administrations waiting lists have continued to balloon – over 1000 homebound elderly, average age 85, languish on case management waiting lists right now. Hundreds wait for home care. Passage of NYHA with universal long term care will end the waiting lists. At one point, there was a 2 ½ year period where not one new client in NYC received EISEP home care under DFTA. This is unimaginable in the Medicaid program. This is astoundingly negligent public policy and service provision – age justice is called for. This is why we have to make Medicaid eligibility irrelevant as the basis for who gets services and how much they receive ***– universal LTC under single payer would be based on need, not income.***

How does an 85 year old person wait for case management or home care? EISEP is not an entitlement like Medicaid, so there are lengthy waiting lists. ***The NY State Health Act would change this – and this is the game changer! Both Assemblymember Dick Gottfried and Senator Gustavo Rivera, Assembly and Senate health chairs, announced at a public event on October 23rd that universal long term care from day one will be amended into the NYHA. This will allow millions of New Yorkers to exhale knowing there will be care for themselves and loved ones. This is an age justice issue – how the city, state and society treats older adults free from discrimination and with full respect.***

The NY Caring Majority Coalition has proposed language be amended into the NYHA that would include the funding of community-based supports, ie – aging services network programs including senior centers, adult day services, meals-on-

wheels, transportation, NORCs, etc – this is a prudent way to spend state dollars. Thousands of seniors with co-morbidities can make use of these community based services in order to remain home. A DFTA funded study found that low income seniors, in their 70's, 80's, and 90's, self-reported improved physical and mental health as a result of attending a senior center over the course of a year (meals, socialization, wellness/exercise programs, etc) – the health care system can't do this. This would allow institutional care funding which is very expensive to be directed towards older adults with more debilitating conditions such as dementia, Parkinson's, stroke victim, etc. The NYHA would establish humane and thoughtful public policy. I can hear that statewide exhale getting louder.

Family caregivers are the backbones of the long term care system, often literally, of care for older adults. Aging and care is a woman's issue – it has often been said the best long term care insurance is having a daughter or daughter-in-law. AARP reports that family caregivers provide 31 billion dollars worth of free care in NY state. That's 31 billion dollars and it's free. This begins to see why the shift to a state single payer bill is also one of equity and fairness to women and families.

Aging is a woman's issue. The needs of women along the lifespan must be included in any woman's agenda. Most older adults are women, most poor elderly are women, women live longer, most family caregivers are women, most home care workers and other care workers are women. Home care workers are overwhelmingly women of color and immigrants who are poorly paid with perilous work conditions. ***This is a racial and economic justice issue. The current long term care system is resting on their shoulders of all these women.*** It is projected that soon 23,000 additional home care workers will be needed in the state. There is an imperative to professionalize the home care industry through higher pay, better work conditions and improved training.

Family caregiving takes a financial and emotional toll. Single payer would guarantee caregivers have adequate health care to take care of themselves. There is a need to address concerns of women across the lifespan. Women lose compensation in salary, pensions, Social Security, promotions, leave their jobs, and often end up living in poverty due to taking time from the workforce for caregiving. This is creating the next generation of elderly poor - 43% of all singles (some of whom are cargivers) depend on Social Security for 90% of their income. Women earn $400-500 less in Social Security monthly while 30% of senior

households have no money left after paying their bills or debt. ***Thousands more don't receive Social Security or Medicare – they're immigrants who couldn't earn these benefits or are undocumented. NYHA covers undocumented New Yorkers. Single payer is also an immigrant issue.***

The RAND Corporation, released its study in August, 2018, "An Assessment of the New York Health Act: A Single-Payer Option for New York State", which included looking at the inclusion of long term care. There would be an additional cost initially which would dissipate over the first decade of the health care program. Universal LTC/single payer would cover Medicare Part B and D and gap insurance. There would be no co-pays or out of pocket costs. The state would be able to negotiate prescription drug prices and medical devices to bring costs way down. Administrative costs, often where the profit is, will be brought down. As a Medicare recipient, I loudly say "yes" to this. So will millions of older adults and people with disabilities who are Medicare recipients. ***New York can afford to do this. New York cannot afford not to do this. This is great for New Yorkers of all ages – an intergenerational win.***

The enactment of A.4738-A/S.4870-A, the New York Health Act, will be a sea change for all New Yorkers. New Yorkers like to think we live in a progressive state. Well, it's time to make real progress on a single payer health care system with universal long term care from day one.

Can't you just hear that statewide exhale now? Let's do this. Let's lead the nation.

New York Health Act Testimony

FOR THE RECORD

Carol J. Clouse

Brooklyn, NY

My family's story is not dramatic, like many stories about healthcare in this country, but our situation is quite common and becoming more so every day.

The freelance workforce in the United States is growing three times faster than the traditional workforce, according to the 2017 Freelancing in America Survey. If this growth continues at its current rate, more than half of US workers will do some form of freelance or gig work by 2027.

My husband and I are part of this growing number of Americans. I'm a freelance writer/editor; he's business technology consultant who works on a project basis. We have one child, who's eight years old.

Two years ago, my husband was laid off from his job at IBM, and since then our healthcare situation has been tenuous.

When he worked for IBM as a salaried employee, we had a good employer-sponsored (silver) plan with Empire Blue Cross/Blue Shield. I've always chosen the silver option—not the best plan with the highest premiums, but not the cheapest plan with the worst coverage. Something in the middle.

When the company laid him off—as part of a general restructuring—my husband was working on a project for the US Department of Interior. The project still needed him, so the project manager helped my husband secure a position with one of IBM's subcontractors. The job paid by the hour, not a salary, but luckily it still came with employer-sponsored healthcare coverage—a decent plan with Aetna, though not as good as our previous one.

Problems began, though, just a few months after the subcontractor hired my husband, when President Trump announced widespread federal budget cuts. My husband didn't get laid off again, but the DOI slashed the budget for the project, and his hours were slashed along with it. So he had to find additional work.

A lot of the type of work my husband does is contract work. He did find another job, but it's a contracted, hourly position with no benefits.

So now, he works two jobs: one full-time as a contractor with no benefits, and one part-time with the IBM subcontractor because, weirdly enough, we still have health insurance through them despite my husband's part-time status. We "have" it, but we could lose it any minute—either because the DOI decides to kill the project, and the subcontractor doesn't have more work for him; or because the subcontractor simply decides they can't afford to offer us healthcare anymore. In fact, at the end of 2017, we thought for sure we were going to lose our coverage. It's a small company, and they sent out a letter saying that, with the cost increase for the coming year, they could no longer afford what Aetna was offering. In the end, though, they found a cheaper alternative.

Our current plan, our third in roughly two years, is through UnitedHealthcare. It's a silver plan and costs us more than $1,200 a month in premiums for the three of us. And it's pretty terrible. The deductibles and co-pays are high compared to our previous plans. For example, I take two medications, and those two prescriptions cost me $165 a month. With our previous Aetna plan, I paid a total of $35.

Moreover, for all the money we pay, we get zero security. We never know if we'll still have this coverage next year or next month, making healthcare a constant source of anxiety. At times, we've toyed with the idea of just buying our own coverage on the NY Marketplace. The problem is the family plans on the marketplace are incredibly expensive and go up significantly every year. (Not to mention that the price for a family plan is the same whether you have one kid or ten. Which helps families who have multiple children, but doesn't do much for those of us who only have one or two.)

The cheapest silver family plan for 2019 is HealthFirst at $1,656 per month. But the doctors we go to now don't take this plan, which makes me wonder how many providers do. Prices then increase, all the way $3,000, with UnitedHealthcare. We can't afford to pay $2,000 to $3,000 a month for health insurance. That's like having a second mortgage or paying rent on two apartments.

Still, I know we're actually pretty lucky. Over the last two years our coverage has gotten progressively worse as our costs have increased, and the insecurity is stressful. But compared to many of the stories you hear about healthcare in this country, people being denied treatment or going into bankruptcy, our story is actually one of better ones.

How sad is that?

In closing, I'd just like to say: We understand implementing a single-payer system will be difficult. We understand our taxes will go up, and there will be a lot to complain about in the beginning. However, my family is willing to pay that price to have healthcare coverage we can depend on. Because people's healthcare shouldn't be at the mercy of corporations that can and will lay you off when they feel they need to. Because people who don't work for a company that subsidizes their health insurance shouldn't have to pay so much more for their healthcare than people who do. And because if all of the corporations, businesses and families in New York pay their fair share in taxes, I cannot imagine that my family will pay more in additional taxes than the roughly $25,000, and counting, we've paid this year in insurance premiums, deductibles, co-pays, etc.

With costs skyrocketing, and the options on the healthcare marketplaces declining, what exactly are we as a nation going to do when more than half the people in this country are freelancers without employer-sponsored healthcare? The gig economy is here. We need to address the healthcare crisis now before spins even further out of control. We need a system that's affordable, permanent and equitable. We need a single-payer system, and New York should lead the way by passing the New York Health Act.

Testimony before the NYC City Council

December 6, 2018

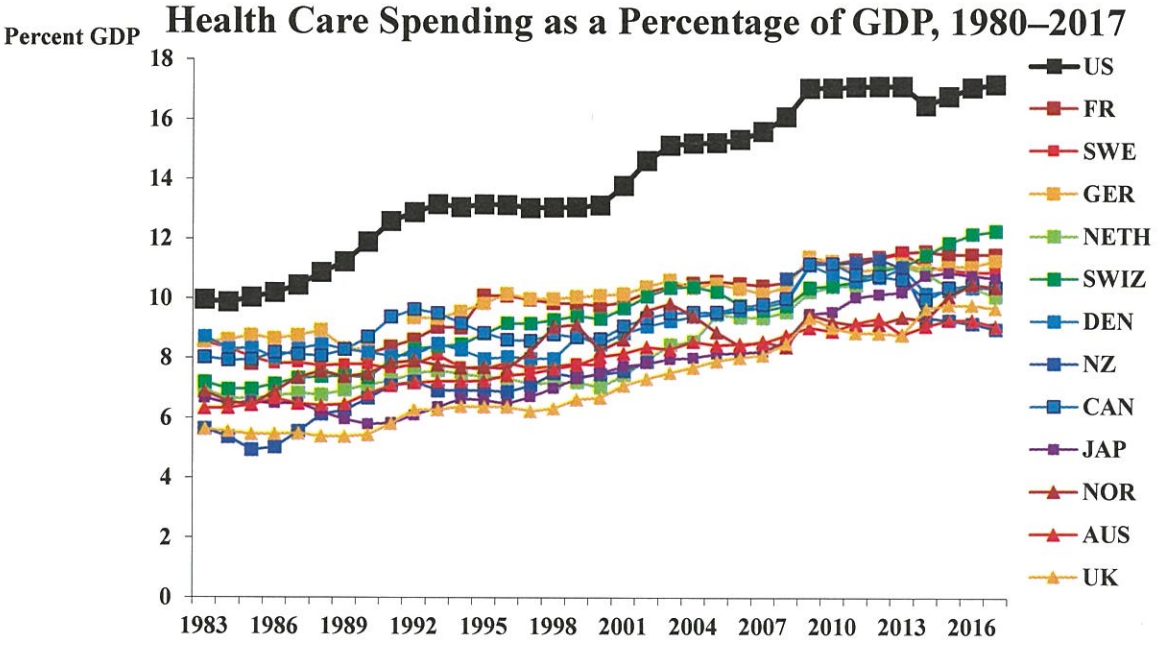
Leonard Rodberg, PhD

The Economics of the New York Health Act

My name is Leonard Rodberg. I am Emeritus Professor of Urban Studies at Queens College, City University of New York. I am also Research Director of the NY Metro Chapter of Physicians for a National Health Program, of which I am one of the founders. PNHP has, for three decades, been advocating for universal, single payer health care.

I am also on the Board of the Campaign for New York Health. In that capacity, I oversaw, along with Assemblyman Gottfried, the economic analysis of the New York Health Act conducted by Prof. Gerald Friedman in 2015. The RAND Corporation has more recently conducted a study of the New York Health Act. I have prepared a summary and evaluation of the RAND report and am attaching it to this testimony.

I want to start with a picture, a graph provided by the highly-regarded Commonwealth Fund. It shows the cost of health care over the last thirty-five years for all of the major countries. As you can see, every other country spends about one-half what we spend, and the amazing thing is that they cover everyone, and they have health statistics – life expectancy, infant mortality, satisfaction with their system – higher than ours.. We spend twice as much, our costs keep climbing, and we have nearly thirty million we are uninsured and millions more unable to pay for their care because they can't afford the deductibles and co-pays.



What do they know that we don't? It is that health care cannot be left to the market. Patients are not in a position, nor do they have the knowledge, to be effective consumers in a marketplace. Government has to see that care is affordable and available when care is needed. And it works, even here, where Medicare and the VA program provide care at costs that are less, and rise more slowly, than care left to the private insurance marketplace. The New York Health Act takes advantage of that experience and knowledge.

The New York Health Act would provide comprehensive health coverage, including long-term care, to all New Yorkers without deductibles, co-pays, restricted provider networks, out-of-network charges, or other out-of-pocket expenses. The system would be funded by a single state fund that would put together existing federal and state funds augmented by a progressively graduated payroll tax and a progressively graduated tax on non-payroll income -- interest, dividends, capital gains. These taxes replace the private insurance premiums and the out-of-pocket costs that we and our employers are now paying. **Most New Yorkers will spend substantially less than they are spending today**, because of the billions of dollars in savings that a single payer system will bring through administrative simplification and through negotiating lower drug prices. **And they will get far better coverage as well.**

The widely-respected RAND Corporation has shown that New York can adopt a universal single-payer plan and spend no more than we are spending now. Small businesses could insure all their employees for an average of between $1,200 and $1,800 per employee, far less than they would have to spend today.

There would be other major financial benefits to all New Yorkers. No one would any longer have to pay deductibles and co-pays. Since NYHA would take over the local share of Medicaid, every county, and New York City, would see its expenses significantly reduced, and their taxpayers would see these reflected in reduced property or other taxes. Medicare recipients would enjoy greatly expanded benefits while no longer having to pay Part B and Part D premiums. And those who are now paying nursing home costs or for home care for their loved ones would no longer have to bear those costs.

We frequently here that costs will skyrocket if we eliminate the deductibles and co-pays that force people to have some "skin in the game" in order to get health care that they need. Just a few hundred miles north of where we are sitting, the Canadians have a universal single payer system that covers all their health care needs, with no cost-sharing. No deductibles, no co-pays. Have their costs gone through the roof? Just the opposite. They spend about 60% of what we spend. Many other countries have no cost sharing and spending far less than we do. Medicaid recipients, veterans in the VA don't have to pay deductibles or co-pays. Neither should we.

Let me dispose of another widely-held misconception, spread by opponents of such a universal program, the claim that savings are achieved by reducing payments to health care providers – doctors, dentists, hospitals, clinics, and so on. This is completely false. **In none of our economic analyses do we project any reduction in spending on payments for health care. In fact, funding for the provision of health care will increase** because those without insurance, and those who now can't access care because they can't afford the deductibles and copays, will be able to receive care and the providers of that care will be paid to provide it.

What will be reduced are the funds that these providers of health care are today forced to spend on billing, fighting with insurance companies to get approval for necessary care, collection agencies, and all the other time and expense of operating and maintaining expensive, and unnecessary, billing systems. Numerous studies conducting over the past twenty years show that more than 10 cents of every dollar they receive is spent on these billing costs. Comparing these costs in the US with the costs in countries that have comparable universal systems shows that their **spending on the provision of care can be reduced an average of 10% through the simplification that New York Health would create.**

In addition, the overhead costs and profits incurred by the private insurance companies approach 20% of their revenues. **These overhead costs will be reduced to between 2-3%, the administrative cost of the unified state fund that would pay for New York Health.**

And our current experience with the Medicaid program, which negotiates reduced drug prices for the more than one-quarter of New Yorkers currently on Medicaid, shows that **we would save one-third of the current cost of drugs by negotiating with the drug companies for everyone.**

If we add these together, we will save a total of $55 billion out of the more than $300 billion we will be spending by 2022 on health care in this state. Because the New York Health Act will extend full access to health care to all New Yorkers, we will be spending an additional $17 billion to provide that coverage. Combined, **there will be net savings of $38 billion, or 12.3% of what we will be spending without this plan.**

Those savings can be spent to do a number of valuable things. The most important is to allow us to **extend access to long-term care to all New Yorkers who need it,** instead of, as at present, only to those willing and able to impoverish themselves to become eligible for Medicaid. We can also **raise physician fees** from the abysmally low fees that Medicaid, and even Medicare pay, so they can afford to see everyone. And we can, with the progressive taxes in the New York Health Act, **take over the local share of Medicaid**, which every county in the state, including New York City, currently has to pay. And it will **cover the Part B premiums that Medicare recipients now have to pay** as well. Medicare recipients should not have to continue paying insurance premiums when every other New Yorker will receive coverage without paying premiums of any kind.

I have calculated what the New York City government would spend under the New York Health Act for health benefits for its employees and New York residents. I have used the tax plan proposed by Prof Friedman but updated using the RAND study with adjustments I have made to it (see the attached report). Today, the City spends $5.9 billion providing health benefits to its employees, along with another $5.9 billion for its local share of Medicaid. Under the New York Health Act, it will spend only $2.4 billion on benefits, a savings of $3.5 billion, and it will no longer have to pay the local share of Medicaid. So **New York City will save a total of $9.4 billion, or 11% of its total budget.**

In short, the New York Health Act is a good deal for the City and a wonderful deal for the residents of this City and State. I strongly urge you to support it.

Thank you.

Summary and Evaluation of the RAND Corporation's Assessment of the New York Health Act: What Can We Learn from RAND about What Single Payer Will Cost? And What Will It Save?

Prepared by Leonard Rodberg, PhD[1] -- October 2018

Executive Summary

The New York Health Act (NYHA) would provide health coverage for every resident of New York, with no premiums, deductibles, or co-pays. Benefits would be fully comprehensive including preventive services and care coordination, dental, hearing, optical, drug, and mental health care. Long-term care would be covered within two years after passage of the legislation. NYHA would be financed through a progressively-graduated payroll tax, paid 80% by employers and 20% by employees, along with a progressively-graduated tax on non-payroll (investment) income.

In response to a request from the New York State Health Foundation, the RAND Corporation performed a study of the impact on health care use and spending of this comprehensive legislation. The principal finding of the RAND report is that NYHA would cover everyone, improve benefits without cost-sharing, cost no more than we are now spending, and provide savings for most New Yorkers. RAND's specific findings are:

- NYHA will expand health care coverage in New York without increasing overall spending through reduced costs of administering the health plan, reduced provider administrative costs, and lower negotiated drug prices.
- Total health care spending would be 2.3% below spending in the status quo, which RAND projects to be $311.2 billion in 2022. Savings would grow over time as these efficiencies take hold.
- In RAND's "base" case, $139 billion in new taxes would replace $141 billion in insurance premiums and out-of-pocket spending.
- Health care payments would decrease for 90% of New Yorkers by an average of $2,800 per person and would increase among the highest-income residents.
- Employers not offering health benefits to their employees today would see an average tax increase of between $1,200 and $1,800 per worker in 2022. This is less than one-half of what health insurance would cost them today.
- There would be a 2% increase in overall state employment (about 180,000 jobs).

RAND used conservative assumptions for estimating program savings, but offered several alternative assumptions based on published research and analysis. These alternatives suggest significantly greater savings in health plan administration and drug and medical device

---

[1] Leonard Rodberg is Professor Emeritus of Urban Studies at Queens College/CUNY and Research Director of the NY Metro Chapter of Physicians for a National Health Program

pricing. We have also considered provider administrative savings, where RAND does not offer an alternative but where published studies suggest further savings. We find that RAND severely underestimated administrative savings for health care providers, including hospitals and physician practices.

The totality of alternatives lead to net savings of $38.1 billion, or 12.3%, for 2022 as compared with RAND's projection for the status quo. The revenue that NY Health taxes would have to raise is then estimated to be $103.3 billion.

These greater projected savings enable improvements and additional coverage to be incorporated into NYHA while still keeping overall spending no greater than what we now spend. These include:

- Raising all physician payment rates to the level currently paid by commercial insurance ($8.8B)
- Paying Medicare Part B premium by the NY Health Fund ($8.5B)
- Paying county Medicaid payments ("local share") by the NY Health Fund ($8.3B)
- Incorporating universal long-term care into NYHA ($18.0B added cost and $11B in current out-of-pocket spending)

The Medicare Part B and local share payments and a portion of the long-term care cost are shifts from current spending, not new spending. Overall spending would still be 3.6% below the status quo projection. New taxes of $157.9 billion would be required under this scenario.

RAND proposed a tax structure which, while progressive overall, imposes new taxes on low-income residents, who today receive care at no cost, and it taxes a dollar earned at $27,500 (the poverty level for a family of four) at the same rate as a dollar at the $141,200 level. We suggest an alternative tax structure similar to one proposed earlier by Prof. Gerald Friedman. This tax plan, which does not tax low-income residents and is progressive throughout the income range, is preferable to that proposed by RAND.

RAND reviewed the question of Federal waivers and expressed concerns about whether they would be available under the current administration. We suggest that, while waivers allowing simplified, unified funding would be desirable, the new single payer publicly-funded system can be operated, if necessary, without receiving such waivers.

1. Introduction

The principal finding of the RAND report is that the New York Health Act (NYHA) would cover everyone, improve benefits without cost-sharing, and provide savings for most New Yorkers. We welcome this important finding that New York can afford a universal single payer health care system with no financial barriers at the point of service.

While RAND's "base" case shows only minimal savings, the study offers alternative assumptions that show much more substantial savings and lower costs. These alternative assumptions are consistent with the findings of many authoritative studies as well as historic experience. This report describes this in detail in sections 3, 6, and 7 below. Using RAND's alternative assumptions, and correcting its error on provider administrative costs, we find that the NYHA, even including substantial improvements and covering long-term care, would achieve significant savings in 2022, and these would increase in future years.

The NYHA would be paid for by progressively-graduated taxes on payroll income and currently-taxable non-payroll income (e.g., capital gains and dividends), with specific income brackets and rates to be enacted through an Executive budget proposal within a year of enactment of the NYHA. The RAND study used a hypothetical set of brackets and rates. An alternative set, based more closely on ability to pay, is described and analyzed below.

2. Purpose of the Study

In response to a request from the New York State Health Foundation, the RAND Corporation performed a study[2] of the impact on health care use and spending of this comprehensive, ground-breaking legislation. The study provides results reflecting a set of 'base" case assumptions as well as results under alternative assumptions. For the first time, it provides an evaluation of the impact of adding long-term care services to NYHA.

3. Background

NYHA would create a publicly-funded single payer health plan called NY Health. The plan would cover all residents of New York State and would provide comprehensive health care with no deductibles, co-pays, or restrictive provider networks. The bill does not currently include long-term care but will likely be amended to do so in 2019. NY Health would be financed through existing federal and state government funds and new progressively graduated state taxes on payroll and currently-taxable non-payroll (investment) income.

There have been at least two dozen economic analyses of single payer plans since the early 1990s. These include studies of both national plans and state-level plans conducted by such organizations as the Lewin Group (a subsidiary of UnitedHealth since 2007), the Urban Institute,

[2] RAND Summary: https://www.rand.org/pubs/research_briefs/RB10027.html
RAND Full report: https://www.rand.org/pubs/research_reports/RR2424.html

and the RAND Corporation. Others have been conducted by persons and groups identified as supporters or opponents of single payer health care. All have reached the same general conclusion: Everyone can be insured for comprehensive care at a cost of no more than we are now spending. Most studies find net savings ranging from a few percent to 15% or so.

In 2015, the Campaign for New York Health, the principal organization advocating for NYHA, sponsored an economic study of NY Health by Prof. Gerald Friedman, Professor of Economics at University of Massachusetts/Amherst. Prof. Friedman had previously conducted studies of HR.676, the national single payer legislation sponsored by Rep. John Conyers, as well as single payer plans in Pennsylvania, Rhode Island, Oregon, and elsewhere. Prof. Friedman, assuming implementation starting in 2019, projected overall savings for NY Health of 15.6%, or $45 billion.

4. Issues to Consider in Conducting and Evaluating Single Payer Studies

A number of issues are unique to the transition to a single payer system, and these have to be included in any study of such a plan. These include cost reductions or savings due to simplified financing with a single payment agency:

- Sharply reduced cost of running the program, replacing insurance company administrative and marketing costs and profits
- Reduced health care provider administrative costs processing bills and handling disputes with insurance companies
- Lower drug prices through enhanced ability to negotiate with drug companies
- Elimination of employer health benefit administrative costs, including state and local government employer costs

There is, on the other side, added spending through expanded coverage and benefits:

- More health care received by the formerly uninsured
- Additional utilization of health care by the formerly underinsured, as a result of eliminating cost-sharing
- Potential for enhanced payments for providers currently dependent on Medicare and Medicaid reimbursement
- Compensation and retraining of workers displaced as a result of administrative cutbacks
- Taking over payment of Medicare Part B premiums as well as other premiums and cost-sharing by Medicare recipients who would now be eligible for comprehensive services like all other New Yorkers without making such payments.

5. Overall Findings of the RAND Study

The key message of the RAND study is that, even using very conservative assumptions, NYHA is affordable to New Yorkers, will reduce spending for almost all of us, and will benefit the state's economy. NY Health would cost less than we will spend if we continue with the status quo. More realistic assumptions, some of which RAND provides, yield even greater savings than those in its base case.

These are the study's main conclusions:

- The New York Health Act will expand health care coverage in New York without increasing overall health spending through reduce costs of administering the health plan, reduce provider administrative costs, and lower negotiated drug prices.
- Total health care spending would be slightly less than spending in the status quo in 2022.
- Savings would grow over time as these efficiencies take hold.
- Regressive premiums, deductibles, copays, and out-of-network charges would end. Instead, health care would be financed by taxes based on ability to pay. In RAND's "base" computation, $139 billion in new taxes would replace $141 billion in premiums and out-of-pocket spending.
- Depending on how progressive the new tax rates are, health care payments would decrease for 90% of New Yorkers by an average of $2,800 per person and would increase among the highest-income residents.
- Employers not offering health benefits to their employees today would see an average tax increase of between $1,200 and $1,800 per worker in 2022. This is less than one-half of what health insurance would cost them today.
- There would be a 2% increase in overall state employment (about 180,000 jobs) due primarily to a progressive reduction in health care costs, leading to more disposable income among low- and moderate-income households. They have a greater "propensity to spend" than upper-income households; that is, they spend a larger share of any additional income, which increases consumption and, in turn, employment.

The RAND "base case" assumes that Federal funds for Medicaid, Medicare, and ACA subsidies will continue to flow to New York. Provider reimbursement rates under NY Health will be equal to the current average rate across payers – Medicare, Medicaid, and commercial insurers -- so there is no reduction in the average payment to providers.

Health care use under NYHA would rise because, with universal coverage and no cost-sharing, New Yorkers, especially the uninsured, the underinsured, and those with low income, would use more health care than at present. Using its microsimulation computer models, RAND estimates that patient demand for hospital care would increase by around 10% and for physician services by around 15%. However, RAND estimates that the actual quantity of services delivered would increase by only half that much because of limits in the supply of services, leading to what RAND calls "congestion" or wait times.

However, historic experience – including the introduction of the Medicare program in the 1960s, the initiation of universal programs in Canada, Taiwan, and elsewhere, and state Medicaid expansions -- show no evidence of significant "congestion" or long waiting times. Physicians and hospitals apply standard medical scheduling practices to take the most urgent cases first, and there is little or no "pileup" in medical offices. Further, freed of the burden of billing- and insurance-related administrative work, doctors and nurses will have more time to see patients, further ameliorating any possible "congestion".

RAND also expresses concern about the viability of a progressive tax schedule. It says that, if only a small percentage of the highest-income residents find ways to avoid taxes, or even move out of the state to avoid them, the schedule would need to be reshaped, increasing the burden on middle- and lower-income residents. However, there is little evidence of this happening when state taxes have been raised on the wealthy in the past. In fact, New York appears, for a variety of reasons, to be increasingly attractive to the wealthy in the recent period.

6. RAND's Detailed Conclusions regarding the Health Care Economy of New York State today and under the New York Health Act

Currently, these are the principal sources of insurance coverage in New York State:

Table 1

Source of coverage	Population (millions)
Employment-base private insurance	9.4
Individual (non-group) insurance	1.8
Medicaid, Essential Plan & CHIP	4.3
Medicare	2.4
Dual Medicaid and Medicare	1.0
Uninsured	1.2
Total	20.1

Under NYHA, everyone would be covered through the state program. Health care expenditures currently projected for 2022 are as follows:

Table 2

Source of Health Care Funding	Payments ($2022 billion)
Employer-based private insurance	84.8
Individual (non-group private insurance	10.4
Federal government (Medicare, Medicaid, etc.)	120.5
State government (Medicaid, etc.)	34.1
Other miscellaneous payments	27.8
Out-of-pocket payments	33.5
Total	311.1

Note that Tables 1 and 2 have been revised slightly from those presented in the RAND study, though the totals are retained unchanged. The changes are explained in the Appendix to this paper.

NYHA taxes would replace the private insurance premiums and a portion of the out-of-pocket payments. (Some out-of-pocket payments would continue, such as those for non-medically-necessary services and over-the-counter, non-prescription drugs. A substantial portion of current out-of-pocket spending is for long-term care, which would be covered by NY Health if the bill is amended to include it.)

These are the results of RAND's base case for 2022. The table separates the basic cost of providing services from the billing- and insurance-related administrative costs. As it shows, NYHA can provide universal coverage with no cost-sharing at a cost that is slightly less than the "status quo" case.

Table 3 RAND "base" case Expenditures ($2022 Billions)

	Status Quo	NYHA	Change (%)
Health care services	255.5	267.1	+11.6 (5%)
Medical care	163.3	173.7	+10.4 (6%)
Prescription drugs & devices	48.1	49.3	+1.2 (3%)
Nondurable medical products	6.0	6.0	0 (0%)
Long-term care	38.0	38.0	0 (0%)
Administration	55.7	41.8	-13.9 (-25%)
Health plan administration	28.5	16.6	-11.9 (-42%)
Provider administration	26.4	24.4	-2.0 (-8%)
State financial administration	0.6	0.6	-0.1 (-8%)
Employer health benefit administration	0.2	0.2	-0.1 (-10%)
Total health care expenditures	311.2	308.9	-2.3 (-1%)

7. Additional Savings

Three items stand out as questionable in Table 3:

1. RAND's base **cost of administering NY Health** is too high. RAND assumes it would have an administrative cost that is 6% of the cost of health service delivery. It bases this on the administrative cost of Medicare and Medicaid, but it includes the administrative costs of the insurance companies that run Medicare Advantage plans and Medicaid managed care organizations. However, NY Health would be run without insurance companies. Its administrative costs would be comparable to those of traditional Medicare and fee-for-service (non-managed care) Medicaid. Experience with those programs and the Canadian single payer health care system shows that the administrative cost of NY Health would be approximately 2%.[3] RAND suggests an alternative assumption of 3% as a lower value. Using that percentage, health plan administration is reduced by an additional **$8.3 billion** beyond its base case, for a total saving of **$20.2 billion**.

2. RAND envisions saving just 8% ($2.0 billion) of **health care provider administrative costs** (that is, only 1% of total health care costs). No alternative assumption is offered, despite many studies[4] showing that these savings would be significantly higher. These

[3] Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. N Engl J Med. 2003; 349:768-75.

[4] J. Kahn et al., "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals," Health Affairs 24, no. 6 (November 2005): 1629–39, doi:10.1377/hlthaff.24.6.1629".

studies suggest that billing- and insurance-related costs amount to around 13% of the total cost of providing health care services in the US. (On p. 28 of its study, RAND appears to assume, incorrectly, that removing these costs should represent a "13% reduction in provider administrative costs", rather than such a reduction in *total* costs, as the data suggests.) If we conservatively assume a saving of 10% of the total cost of providing service, through the simplification that accompanies introduction of a single payer, we find an additional saving (beyond RAND's base case) of **$14.3 billion**, for a total saving of **$16.3 billion**.

3. RAND assumes a **reduction in drug prices** of just 10% below Medicare Part D prices, rather than 33% below, which it estimates Medicaid already achieves nationally as in New York State (see RAND's Table 2.3 and Table 4.1). NY Health, negotiating for 20 million customers, should be able to negotiate even greater reductions than Medicaid can. If we follow RAND's alternative assumption of a 33% reduction for an achievable lower price, there will be an additional **$13.1 billion** in savings, for a total saving of **$18.6 billion** below what these drugs and devices would cost.

Thus, using well-documented values for administrative savings and drug price reductions, both suggested by RAND, and correcting for the error RAND made in estimating provider administrative savings, there will actually be an additional **$35.8 billion** beyond the minimal savings that RAND found, for an **overall saving of $38.1 billion**, or **12.3%,** below the status quo.

With these revised assumptions, based on solid research data, the change in spending under NYHA now looks like this. We will refer to this modified base case as RANDmod:

Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Cost of Health Care Administration in the United States and Canada," New England Journal of Medicine, no. 349 (2003): 768–75.

Aliya Jiwani et al., "Billing and Insurance-Related Administrative Costs in United States' Health Care: Synthesis of Micro-Costing Evidence," BMC Health Services Research 14, no. 556 (2015) http://www.biomedcentral.com/content/pdf/s12913-014-0556-7.pdf

David U. Himmelstein et al., "A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far," Health Affairs 33, no. 9 (September 1, 2014): 1586–94, doi:10.1377/hlthaff.2013.1327.

Morra, Dante, et al. "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers." *Health Affairs* 30, no. 8 (2011): 1443 –1450. doi:10.1377/hlthaff.2010.0893.

Table 4 RANDmod Expenditures ($2022 Billions)

	Status Quo	NYHA	Change (%)
Health care services	255.5	253.9	-1.6 (-1%)
Medical care	163.3	173.7	+10.4 (6%)
Prescription drugs & devices	48.1	36.2	-6.5 (14%)
Nondurable medical products	6.0	6.0	0 (0%)
Long-term care	38.0	38.0	0 (0%)
Administration	55.7	19.1	-36.6 (-66%)
Health plan administration	28.5	8.3	-20.2 (-71%)
Provider administration	26.4	10.1	-16.3 (-62%)
State financial administration	0.6	0.6	-0.1 (-8%)
Employer health benefit administration	0.2	0.2	-0.1 (-10%)
Total health care expenditures	311.2	273.1	-38.1 (-12%)

Note that the numbers for prescription drugs appear somewhat different from the savings figures cited in paragraph #3 above. That is because this table includes the increase in drug utilization found in RAND's microsimulation of patient care-seeking and physician and hospital care-providing behavior.

According to RAND's original "base case" estimates, replacing private insurance premiums and out-of-pocket expenses with new taxes will require raising $139.1 billion through these taxes. These additional taxes replace **$141 billion** in private insurance premiums and out-of-pocket spending. The greater savings in RANDmod will reduce those taxes to **$103.3 billion**, for a saving of **$35.8 billion** below RAND's projection of spending under NYHA..

8. Improvements in the NY Health Plan

These additional savings allow us to consider using those savings to meet some other specific needs, namely, services, raising physician fees, paying the Medicare Part B premium, covering the county share of Medicaid expenses, and including universal long-term care.

1. **Physician fees:** Many physicians in New York State find the fees that Medicare and Medicaid pay inadequate to maintain their practices successfully. RAND presents data that can be used to estimate what it would cost to raise their rates to commercial levels.

   RAND provides a useful table (Table 2.3, page 11) comparing the average current reimbursement rates paid by private insurance, Medicare, and Medicaid to hospitals, physicians, and for medications in New York State:

Table 5 Relative Provider Payment Rates and Prescription Drug Prices in NYS

Health Care Service Category	Private Insurance	Medicare	Medicaid	All-Payer Weighted Average
Hospitals	1.20	0.93	0.89	1.00
Physicians	1.20	1.11	0.62	1.00
Prescription drugs	1.27	1.01	0.63	1.00

RAND uses the all-payer weighted average in its computations. The table shows that the all-payer reimbursement rate that RAND uses for physicians is below what Medicare currently pays, a rate that, as we noted, many physicians already find inadequate. Drawing on this table and on the RAND result that physician revenues in 2022 under its base case would be $48.7 billion (Table 5.3), or $43.8 billion with the administrative savings identified in Section 7, raising them to a level where all physicians would be reimbursed at private insurance rates would cost **$8.8 billion**.

2. **Medicare Part B premiums:** Currently, Medicare recipients who wish to receive coverage for physician services must pay a monthly premium amounting to more than $100 per month. Under NYHA, the state would take over the payment of Part B premiums, so federal Medicare funding would continue to come into NY. Medicare recipients would receive the same benefits as all New Yorkers, without incurring expenses other than the NY Health tax on taxable income they might have. (NY Health benefits and terms are more generous than those of Medicare, just as they are more generous than commercial coverage.) According to RAND, that will cost an additional **$8.5 billion** in 2022.

3. **County Medicaid payments:** Currently, the counties of New York State, including New York City, pay a total of **$8.3 billion** ("local share") of New York's Medicaid costs (the amount is statutorily capped). Since NYHA provides NY Health will pick up the local share (using revenue from the new payroll and non-payroll taxes), this would add that amount to the new tax. (RAND has not included that in its computations; its revenue projection, Table 5.4, assumes that state and local taxes remain essentially unchanged.)

4. **Long-term care:** RAND estimates that adding long-term care services to the services covered by NYHA, using the same universal, no-cost-sharing principles as for medical care, would cost about **$18 billion** in 2022. It assumes 50% of informal home care (i.e., unpaid care provided mainly by family members) would be replaced by paid care, with 90% of this increase going to home care and 10% to nursing homes. This leads to a 200% increase in paid home care and 10% increase in nursing home care. This is consistent with an estimate of $20 billion which a Physicians for a National Health Program NY Metro Working Group made several years ago.[5] New Yorkers currently spend about $11 billion annually on long-term care insurance and out-of-pocket expenses, and NY Health would take over those expenditures. Thus, while total expenditures would increase by **$18 billion**, NY Health taxes would increase by **$29 billion** to cover all long-term care costs.

[5] PNHP-NY Metro Working Group, A Proposal for Incorporating Long-term Care into the New York Health Act, 2016, www.infoshare.org/main/Incorporating_Long-term_Care_into_the_New_York_Health_Act.pdf

Note that neither the Medicare Part B premium payment nor the county Medicaid payment, nor a portion of the long-term care expenses, are *new* expenditures. Each is simply a shift of spending from one pocket (Medicare recipients, county governments, families) to another (NYHA). Total spending by New Yorkers for health care would remain substantially below RAND's status quo projections: Without adding universal long-term care, the total would be **$281.9 billion**, or **$29.3 billion (9.4%)** below status quo projections; with long-term care included, the total would be **$299.9 billion**, still **$11.3 billion (3.6%)** below projected spending in the status quo.

Accounting for all four of these expenses – covering long-term care, raising physician fees, picking up Medicare Part B premiums, eliminating the local share of Medicaid -- would add **$54.6 billion** to the $103.3 billion to be raised through the new NYHA tax, for a total of **$157.9 billion**. These taxes replace a total of **$169.2 billion** in current spending on private insurance premiums, out-of-pocket spending, Medicare Part B premiums, and local Medicaid costs.

Advocates for NYHA have been relying on the study conducted by Prof. Gerald Friedman since it was released in April, 2015. Here is a comparison between the RAND base-case results, our RANDmod, and Friedman's work:

Table 6 Comparison of RAND, RANDmod & Friedman

Additional Costs	RAND	RANDmod	Friedman
	$2022 B	$2022 B	$2019 B
Covering the uninsured & Elimination of cost-sharing	17.1	17.1	15.2
Enhanced physician fees	--	8.8	10.8
Total Costs	17.1	25.9	26.0
Savings			
Reduced insurance admin costs	11.9	20.2	28.6
Reduced provider admin costs	2.0	16.3	20.7
Bulk purchase of drugs & devices	5.5	18.6	16.3
Reduced fraud	0.0	0.0	5.4
Total Savings	19.4	55.1	71.0
Net Dollar Savings	2.3	29.2	45.0
Percent Savings	0.7%	9.4%	15.6%

RAND's "base" case uses conservative assumptions which were discussed earlier. Within the wide margins of uncertainty in such future-oriented studies, the modified RAND base case and Friedman's results are clearly compatible with each other.

9. Tax Proposals

The new NYHA payroll and non-payroll taxes replace the private insurance premiums, deductibles, copays, and out-of-network charges of the status quo. Using our revised assumptions for spending under NYHA, we find the following revenue needs that must be provided by the NYHA taxes:

Table 7 Required tax revenue ($2022 billions)

RAND base case	139.1
RANDmod	103.3
RANDmod w/improvements w/o long-term care	128.9
RANDmod w/improvements incl. long-term care	157.9

These funds replace spending on private insurance premiums and out-of-pocket costs and also pay for the "improvements" described above.

RAND proposed the following tax structure:

Table 8

Wage & Nonwage Income	Wage Marginal Rate	Nonwage Marginal Rate
≤ $27,500	6.1%	6.2%
$27,501-$141,200	12.2%	12.4%
>$141,200	18.3%	18.6%

Note that the "marginal" rate only applies to income within that particular bracket. For a given individual, the actual effective rate would reflect the fact that income in lower brackets is taxed at a lower rate. For example, under RAND's structure, someone earning $28,500 would pay 6.1% of $27,500 plus 12.2% of $1,000, for an effective rate of 6.31%.

However, this structure does not meet some general criteria for the kind of progressive tax structure advocates for NY Health would like to see. It taxes low-income residents who qualify for Medicaid today and receive care at no cost, and it taxes a dollar earned at the $27,501 level (poverty level for a family of four) at the same rate as a dollar at the $141,200 level.

It is important to note that this bracket structure is just a hypothetical example chosen by RAND. The study states, "Many different tax schedules with varying degrees of progressivity and regressivity could be established to meet the financing needs of NYH; we present one set of possible rates" (Page 24). Other plans would be just as valid and more consistent with the equity goals of NYHA.

This table shows the tax structure proposed in 2015 by Prof. Friedman:

Table 9

Wage & Nonwage Income	Marginal Rate
<$25,000	0%
$25000 - $49,999	9%
$50,000 - $74,999	11%
$75,000 - $99,999	12%
$100,000 - $199,999	14%
$200,000 or more	16%

Advocates for NYHA much prefer this structure, which does not tax low-income residents and raises the tax rate progressively as income rises.

RAND projects that wages will rise at a rate of 3.1% per year over the coming decade, while overall personal income will rise 3.5% (implying that non-payroll income will rise faster than payroll income, which it certainly has been doing in recent years). Using those rates and the projected population growth rate of 0.4% per year, the Friedman tax structure and tax rates, which are projected to yield $91 billion in 2019, would yield about $102 billion in 2022. Thus the tax structure in Table 9 would pay for the basic NY Health plan under the assumptions incorporated into RANDmod.

This covers the cost of NY Health under RAND's alternative assumptions (with the modifications discussed above), although not the "improvements" described in Section 8. To fund these, we would suggest using the following revised tax table:

Table 10

	Marginal Rate w/o long-term care	Marginal Rate w/long-term care
<$25,000	0%	0%
$25000 - $49,999	11.3%	13.8%
$50,000 - $74,999	13.8%	16.9%
$75,000 - $99,999	15.0%	18.4%
$100,000 - $199,999	17.6%	21.6%
$200,000 or more	20.1%	24.6%

The following table shows the effective tax rate at each income level, using these marginal tax rate brackets for each situation of "improvements":

Table 11

Income	Effective Tax Rate w/no "improvements":	Effective Tax Rate with "improvements" w/o long-term care	Effective Tax Rate with "improvements" incl. long-term care
$25,000	0%	0%	0%
$50,000	4.5%	5.6%	6.9%
$75,000	6.7%	8.4%	10.2%
$100,000	8.0%	10.0%	12.2%
$200,000	11.0%	13.8%	16.9%

10. Federal waivers

RAND suggests that federal waivers would be required to continue receiving federal health care funding. It questions whether these waivers would be available to facilitate incorporating Medicaid, Medicare, and Affordable Care Act funds into NY Health.

NY Health can be implemented more easily if New York receives federal waivers relating to Medicare and other federal programs. However, NY Health can be implemented without federal waivers.

First, NYHA does not call for any new or increased federal spending. Thus, it would not violate federal "budget neutrality," which might have triggered the need for a waiver or made a waiver unlikely to be obtained.

New York Medicaid has always covered populations, payment levels, and services beyond those that qualify for federal matching funds. Outside the perimeter of federal Medicaid, we do what we want with our own money. We only have to document to CMS what expenditures qualify for federal matching; the rest remains State-only. NY Health would not change this, and we would continue to draw down the same federal matching money.

Child Health Plus can be folded into NY Health the same way Medicaid can. We currently run CHP through managed care plans (as we choose to do with most of Medicaid), but it can be run without managed care plans, as Connecticut does, without a waiver.

For Medicare, NY Health could operate as "wraparound" coverage, filling in the gaps in Medicare, as the EPIC drug program does and New York Medicaid does in some circumstances. New York could also set up a Medicare Advantage plan (but without any restricted provider network or coinsurance and with NY Health funds picking up the cost-sharing) which New York Medicare recipients would be invited to join. The plan would receive ordinary Medicare Advantage payments from CMS. Under existing federal law, New York can choose to raise the eligibility level for "qualified Medicare beneficiaries" (QMB) as high as we want, enabling the State to pick up Part B premiums and coinsurance for all recipients.

CMS could give New York a Medicare waiver, under which it would simply send the state a check every month for what it would have spent on Medicare benefits for New York residents; that would save the federal government some administrative costs and make NY Health easier and less expensive to run. But if CMS is not willing to do that, then either the wraparound or Medicare Advantage model could work as an alternative, without a waiver. Under any scenario, the NYHA would guarantee that every Medicare recipient receives more generous benefits than they receive today.

11. Conclusions

RAND has provided valuable new data and support for the concept underlying the New York Health Act. It has demonstrated that it is a feasible plan which New York can afford and which will benefit the vast majority of its residents. The study includes alternative assumptions that are actually more realistic than RAND's original one and that make the plan more affordable and beneficial for New Yorkers and for the New York economy. While this paper has focused on the economics of NYHA, we should remember the broader benefits of NYHA which will included improved health outcomes for New Yorkers, reduced health disparities, reduced absenteeism, lower health care costs for employers, and an improved climate for entrepreneurship.

APPENDIX

Currently, these are the principal sources of health insurance coverage in New York State (from Table 5.1 in the RAND report for 2022):

Table A1

Source of coverage	Population (millions)
Employment-base private insurance	9.6
Individual (non-group) insurance	0.3
Medicaid, Essential Plan & CHIP	4.9
Medicare	2.9
Dual Medicaid and Medicare	1.0
Uninsured	1.4
Total	20.1

Health care expenditures projected by RAND in Table 5.4 for 2022 are as follows:

Table A2

Source of Health Care Funding	Payments $2022 billion
Employer-based private insurance	84.8
Individual (non-group private insurance	1.9
Federal government (Medicare, Medicaid, etc.)	120.5
State government (Medicaid, etc.)	34.1
Medicare (Part B)	8.5
Other miscellaneous payments	27.8
Out-of-pocket payments	33.5
Total	311.1

There are several problems with these tables, which are drawn directly from the RAND report:

1. The number of people on individual insurance, and the payments from individual insurance, are much too small. The recent report on health insurance trends from the NYS Health Foundation indicates that 9.9%, or 2 million, New Yorkers have what they refer to as "direct payment" coverage (the Census Bureau estimates that 2.53 million are on such individual coverage, while 10.88 million are on employer-based coverage)[6]. Thus, there are at least 2 million more New Yorkers

[6] "Success in the Empire State: Health Insurance Coverage Trends", NYS Health Foundation, November 2017. https://nyshealthfoundation.org/resource/success-in-the-empire-state-health-insurance-coverage-trends; Current Population Reports, P60-260, Health Insurance Coverage in the United States: 2016, U.S. Government Printing Office, Washington, DC, 2017. Supplemental data showing detailed data by insurance type: Table HIC-4_ACS. Health Insurance Coverage Status and Type of Coverage by State All People: 2008 to 2016. https://www.census.gov/library/publications/2017/demo/p60 - 260.html

on private insurance than RAND figures indicate, and health care payments from private insurance (Table 2) have to be increased accordingly. (In fact, RAND's Table 2.1 shows a more accurate number for non-group insurance, but that table is not used in its later material.) The numbers for Medicare and Medicaid also need revision. Table A1 (rev) shows revised population numbers:

Table A1(rev)

Source of coverage	Population (millions)
Employment-base private insurance	9.4
Individual (non-group) insurance	1.8
Medicaid, Essential Plan & CHIP	4.3
Medicare	2.4
Dual Medicaid and Medicare	1.0
Uninsured	1.2
Total	20.1

2. Table A2 shows payments to the health care system from the various funding sources. Therefore, the Part B premiums that Medicare recipients pay to the federal government should not appear here. Those funds go into the federal government's coffers to help pay for the contribution that the federal government makes to pay for health care services in New York (here, $120.5 billion). Including it explicitly in the table would amount to double-counting. Thus, a revised Table A2 must be created.

   We don't have estimates of what amount individual insurance pays towards health care expenses, but it is probably between $10-20 billion, based on what employer-based insurance pays per person. For simplicity, we have selected a value which keeps total spending at the same value as RAND has used in its analysis.

Table A2(rev)

Source of Health Care Funding	Payments ($2022 billion)
Employer-based private insurance	84.8
Individual (non-group private insurance	10.4
Federal government (Medicare, Medicaid, etc.)	120.5
State government (Medicaid, etc.)	34.1
Other miscellaneous payments	27.8
Out-of-pocket payments	33.5
Total	311.1

The main implications of these changes are (1) insurance plan administrative costs – and, consequently, administrative savings when moving to NYHA – will be greater because more health care financing goes through private insurance companies, and (2) Medicare Part B premiums are not part of the direct payment for health care and should not be treated as such in the computations.

cphs*
*putting the public back in public health

Testimony at the City Council Health Committee - Res 0470-2018

December 6, 2018

110 Wall Street * NY * NY * 10005 * Suite 4006

www.cphsnyc.org afeliciano@cphsnyc.org

Good afternoon,

My name is Anthony Feliciano; I am the Director of the Commission on the Public's Health System (CPHS and a coalition member of the Campaign for New York Health. We like to thank Speaker Corey Johnson for introducing a Resolution calling on the State Legislature to pass and the Governor to sign the New York Health Act A.4738-A/S.4840-A, legislation that would establish the New York Health program, a universal single payer health plan for all New York State residents. We also like to thank Councilmember and Chair of the Health Committee Mark Levine for holding this hearing. In addition, the 31 members of the NYC Council who have sponsored the Resolution.

We believe in putting the public back in public health. For over 25 years, we have been addressing inequities in the care, treatment, delivery and distribution of health care services, programs, and resources. New York has long been a healthcare reform front-runner, guaranteeing insurance for various populations decades ahead of the Affordable Care Act (ACA), and also expanding Medicaid to cover many low-income parents and childless adults long before the ACA reformed the nation's health insurance system. So the ACA's expansion of Medicaid has been particularly beneficial to New York from a financial and social perspective. Medicaid as of January 1, 2014, and between the fall of 2013 and August 2018, the state's total Medicaid enrollment grew by 14 percent, to nearly 6.5 million people. And New York State of Health, the state-run health insurance exchange, reported that nearly 3 million of those enrollees were enrolled via the exchange as of 2018. [1] I state these numbers solely because we can do even better. A Universal Single Payer

legislation in New York State would provide an important step to improve access to comprehensive care regardless of income, pre-existing conditions or ability to pay — a tremendously important feat that would benefit many

I believe strongly that creating conditions for health and wellbeing require many solutions. CPHS support "Medicare for All", but we know insurance alone does not solve the serious, persistent and growing health equity problems we have with health outcomes in NYS. But health care shouldn't be a business. It should be a public good instead. It is a human right.

I know one of the major argument against a universal single payer system is about cost to the government. But our current health care system is actually already extremely expensive and what about the millions of New Yorkers who paid the human toll and price for the high cost of care. Would it not be beneficial to be able to negotiate favorable terms with drug companies and service providers? Nobody should ever be unable to afford the care they need.

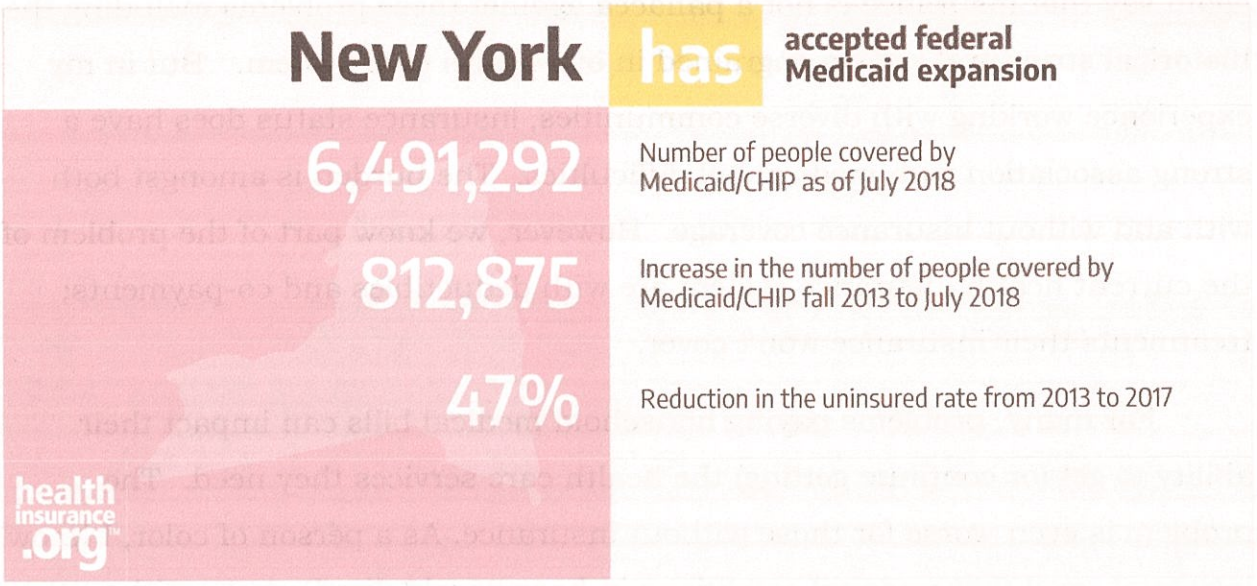
We know already through the state's Medicaid Redesign efforts through DSRIP that a lot of that money doesn't go directly toward keeping people healthy. Instead it goes to the overhead costs in many hospitals (would exclude true safety net facilities like the public hospital system) and insurance industry to keep businesses running. These include exorbitant executive salaries, marketing to beat out the competition, the labor-intensive work of assessing and denying claims and so on. None of these would be a factor when it comes down to the total expenditures and administrative costs if New York State Legislature passes and the Governor signs into law the NY Health ACT. I am not going to go into providing detailed arguments around the economics that we feel favor a Universal Single Payer System. I will let our academic and single payer advocate colleagues address those points. But I will discuss a few important issues about why it would be an important step for the State.

No one should be forced to ask themselves do I pay the hospital bill or do I pay the utility bill or food at the table or roof over my family's head? I will again say that insurance is not a panacea against these problems including the historical structural racism engrained in our health care system. But in my experience working with diverse communities, insurance status does have a strong association with medical bill difficulties. The burden is amongst both with and without insurance coverage. However, we know part of the problem of the current health insurance system are with deductibles and co-payments; treatments their insurance won't cover.

For many, problems paying household medical bills can impact their ability to get (or continue getting) the health care services they need. The problem is even worse for those without insurance. As a person of color, I know intimately well that unequal conditions in how marginalized communities are treated and the difficulties we face accessing quality health care. I'm horrified by the many stories I hear about discrimination and racism. But it is not an either or. The NY Health Act is one major solution to one form of discrimination. The City Council support for Universal Single Payer can send a strong message to the State by passing the Resolution. No more co-pays, deductibles, or premiums! And as the fight continues around passage of the Bill, we can simultaneously combat the other inequities faced by low-income, immigrant and communities of color, women, children/youth, people with disabilities, people formerly incarcerated, and LGBTQ.

The system we have, the status quo is not acceptable. We cannot continue having New Yorkers skipping health care because of issues like affordability. We cannot continue to rely on major players, like health insurance industry, to continue to be reliable partners in delivering health care.

Thank you



1. Source: https://www.healthinsurance.org/new-york-medicaid/

I am here as a New Yorker, and international epidemiologist and health economist in support of the New York Health Act. This Act represents New York State joining global efforts outside the US ensuring universal access to healthcare and a public health focus that makes everyone important and keeps track on how well we're achieving our healthcare priorities as a state. This includes prevention and treatment of cancer, cardiac disease, and the like. The NYHA will be administered via separate geographic sections of our state, which allows critical assessment of unmet need, such as where we need more doctors and hospitals, more nurses, more rehabilitation facilities and nursing homes.

What NYHA needs once passed is cost control measures to ensure an affordable, cost effective state health system, one like the rest of the world. What we know from all other countries (except ours), is that cost controls helps to create a workable budget. A workable budget requires negotiating drug prices based on clinical outcomes. The list is endless on what New York State can do, based on what other countries have been doing from my experience. The bill should also include what's called a Preferred Drug Program, a measure that allows prescribing of medications without any pre-authorization that are demonstrated to achieve optimum health outcomes with demonstrated cost-effectiveness—meaning cost is commensurate with how much patients benefit. No me-too drugs that cost more. No high cost new drugs with negligible clinical benefit over current gold-standard treatment.

I urge the City Counsel to demand passage of this bill to ensure all New Yorkers access to healthcare, with measures that include cost control of drug treatment and a Preferred Drug Treatment program. It's important to the health of New Yorkers, to the economic solvency of our vibrant healthcare system that includes some of the best hospitals in the country, if not the world. What good is it if all New

Yorkers can't get access? This is what the NYHA ensures. And why the City Council should and needs to endorse this bill.

To: Speaker Corey Johnson and Members of the New York City Council

From: Marva Wade, RN, Board Member New York State Nurses Association

Date: Thursday, December 6th, 2018

Re: Official testimony in support of Resolution 470 in favor of the New York Health Act

Good afternoon, my name is Marva Wade and I am registered nurse and board member of the New York State Nurses Association (NYSNA), representing the interests of 42,000 registered nurses (RNs) and the patients we serve. We are here to tell the Council that we enthusiastically support the New York Health Act – an improved Medicare for All program in New York State – that would establish a comprehensive system of universal healthcare for every single resident.

This bill would provide New Yorkers with healthcare coverage without regard to age, income, health or employment status. It would be paid for fairly through progressive taxation based on what you can afford, and there would be no financial barriers at the point of delivering care. Benefits would include all medically necessary health services including preventive and primary care, hospital care, dental, vision care, prescription drugs, mental health, addiction treatment and rehabilitative care.

New York nurses are on the frontlines every day, helping patients navigate the complexity of our healthcare system. Unfortunately, our members are all too familiar with the failure of the healthcare system to meet the needs of patients in both highly complex cases such as the financial devastation that so many cancer patients face; as well as the deadly consequences of not being able to afford basic healthcare for chronic conditions. Just ask any person with diabetes how much they fear being without health insurance for even a short period of time.

It is heartbreaking to see patients denied or dangerously delay care because they simply cannot afford treatment. But it is a moral outrage that this is happening in the richest country in the world where we spend more on healthcare than anywhere else on the planet. This broken, but obscenely expensive healthcare system is delivering health outcomes nurses are ashamed of, all while increased privatization continues to move our health in the wrong direction. For example, while maternal mortality is declining in every other industrialized country, maternal mortality is actually increasing in the United States, especially for black women. Life expectancy gains are also reversing in the U.S., including for white men. Our people are facing horrific realities trying to receive the most basic mental health and substance abuse treatment.

While we know that there are many factors at play in determining the health outcomes of a population, one very important ingredient in reversing these shameful health outcomes is timely and accessible healthcare. That is something nurses are trained to deliver, but only if we have a system that allows us to put the needs of our patients ahead of the profits of a few.

It is no secret that nurses are passionate advocates for an improved Medicare for All system in New York State and the country to meet the moral imperative of guaranteeing high quality healthcare for all. We want to guarantee that the progress we make toward healthcare for all lifts the boats for every working person. We believe our advocacy is for a plan that guarantees workers currently receiving healthcare benefits through a collectively bargained contract will see the same or better benefits with an improved Medicare for All program. For the record, NYSNA is committed to working with our brothers and sisters in labor to address any concerns they may have as Medicare for All legislation moves forward through the democratic process.

With attacks on the ACA and relentless insecurity in federal healthcare funding, nurses are compelled to speak up for the New York Health Act as a solution, creating a unique funding stream to protect against federal cuts, while guaranteeing high quality healthcare to all residents. The New York Health Act would reform healthcare in New York and serve as an inspiration for the rest of our country, putting more money in the pockets of nearly all New Yorkers, including nurses, small businesses, municipalities and the state. Most importantly, by reducing the number of New Yorkers without healthcare and removing financial barriers to accessing care, these improvements would save thousands of lives each year. This legislation is an economic and moral imperative, and the New York State Nurses Association is passionate about seeing it enacted into law.

Thank you for the opportunity to testify today.

New York City Council Committee on Health

Hearing Testimony: "The New York Health Act"

David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy

GREATER NEW YORK HOSPITAL ASSOCIATION

Chair Levine and other members of the Health Committee, my name is David Rich, Executive Vice President for Government Affairs, Communications, and Public Policy at the Greater New York Hospital Association (GNYHA). GNYHA's members include all of the hospitals in New York City as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

We start this discussion with a fundamental tenet of our Association: health care is a human right.

Our members exhibit this in a variety of ways:

- **Unique among health care providers, hospitals provide care for New Yorkers 24 hours a day, 365 days a year, at the times of New Yorkers' greatest need, saving lives at every moment of every day.** Also unique among health care providers, our hospitals and their staff take care of New Yorkers regardless of their ability to pay or insurance status. Our hospitals, both public and voluntary, serve huge numbers of Medicaid patients and provide the same quality of care to all. The extraordinary health care infrastructure our hospitals have developed benefits all of us.

- Our City's academic institutions and specialty hospitals provide world-class care for their communities, and conduct advanced research, educate and train tomorrow's physicians and other clinicians, and invest in the best technologies for their patients.

- **GNYHA and our member hospitals have long and strongly supported expanding access to quality care for all.** We have fought long and hard for universal insurance coverage. GNYHA along with 1199SEIU, the American Medical Association, and others worked hand-in-glove with the White House in the early days of President Obama's Administration to lay the foundation for what became the Affordable Care Act (ACA), commonly known as "Obamacare." In the last two years we waged a nationwide campaign against repeal of the ACA. GNYHA and the GNYHA-1199SEIU Healthcare Education Project have spent tens of millions of dollars in support of New York's Child Health Plus and Family Health Plus programs and New York's Essential Plan. In the 1990s, we joined with the City and helped fund a major initiative to get people enrolled in the Medicaid program.

  Under Governor Andrew Cuomo's leadership and working with other stakeholders in New York's health care community, we have together succeeded in improving the current system by cutting the number of uninsured New Yorkers almost in half, to 5% across the State, an historic low. Our record of support for expanding access to health care is second to none. Having said that, more must be done to ensure that every New Yorker has access to the health care they need. More than a million New Yorkers remain uninsured, with over 600,000 in New York City.

Yesterday, at a GNYHA Board of Governors meeting, our members discussed our position in relation to the New York Health Act (NYHA). **We reaffirmed our commitment to the truth that health care is a human right and to many of the goals of NYHA's sponsors, Assemblyman Richard Gottfried and Senator Gustavo Rivera. At the same time, however, we respectfully submit that there are huge**

obstacles in the way of NYHA reaching these goals, and we do not believe these obstacles can be overcome. They include:

- Disrupting the health care coverage of 95% of New Yorkers, including seniors who are Medicare and Medicaid beneficiaries and the millions of New Yorkers who are covered by employer-sponsored health plans.

- NYHA would also render uninsured hundreds of thousands of residents in other states who work in New York and currently receive health insurance through their New York employers. To ensure they would not be uninsured, their employers would have to contract with insurers in other states who then would need to negotiate rates with providers in those states as well as providers in New York so these New York workers could access health care while at work or at home. This could be more costly than the coverage currently provided to them.

- New York lacks the Federal partner it needs to make NYHA happen. NYHA implementation would require several Federal waivers. Yet Seema Verma, the current administrator of the Centers for Medicare & Medicaid (CMS), has already stated that no waivers to establish single payer systems would be approved.[1] And, in fact, the likelihood of a subsequent administration approving such a waiver is highly questionable as CMS has never approved a waiver that turned over Medicare funding and administration to a state.

- Because there would be no new Federal funds available, NYHA would require a 156% increase in State taxes that could crowd out spending on all other State budget items, including education, emergency preparedness, and other vital State functions. According to the Rand Corporation analysis, it could also cause wealthy New York taxpayers to flee the State, diminishing the tax base and creating additional budget pressures.[2] NYHA's massive cost—$139 billion according to RAND Corporation—is prohibitive, and the significant disruptions it would cause are both potentially damaging to New York's health care system and New York's economy.

- NYHA would cut payments to hospitals by large amounts and endanger the fiscal health of academic medical centers and safety net hospitals alike, jeopardizing the health of the communities they serve.[3] Under NYHA, all hospital payments would be set by the State and subject to annual budget constraints, just as they are currently under Medicaid. Medicare rates are subject to similar budgetary pressures.

  Today, these government payers—Medicaid and Medicare—fall far short of covering the costs incurred by hospitals in caring for patients. This is sadly the history we have with government-run insurance programs. While some would argue that a single payer system such as NYHA could provide additional support to struggling safety net institutions, there is limited evidence to suggest this could be sustained over a period of time. Despite the best intentions of state policymakers, the first economic recession that significantly impacted State revenues would force State budget

[1] Dickson, Virgil, "Verma Will Reject Any Single-Payer State Waivers," Modern Healthcare, July 25, 2018.
[2] https://www.rand.org/pubs/research_reports/RR2424.html
[3] https://www.empirecenter.org/publications/the-impact-of-single-payer-on-new-york-hospitals/

cuts and NYHA, far and away the largest component of the State budget, would be the most obvious target. For the most likely result, we have only to look at the last recession, which resulted in Medicaid rate cuts and a subsequent hospital rate freeze that lasted a decade.

- Thousands of unionized workers in New York City have excellent health benefits, many paying no premiums, copays, or deductibles. This includes unionized hospital workers, such as the members of 1199SEIU. Under NYHA, they would get no more benefits than they currently enjoy *and* pay a new payroll tax. We have already heard considerable concern expressed by public sector unions about the impact of NYHA on their hard-won health care benefits.[4]

For these many reasons, GNYHA believes it is impractical to enact a single payer system at a state level.

However, we can and should implement additional policies and programs to expand insurance coverage and improve the health system for all New Yorkers by building upon the successful strategies that have brought coverage to more than a million New Yorkers over the last five years.

- **People are rightly upset with high copays and deductibles, with insurance company denials of care, and the red tape associated with private insurance.** The State can take action to help New Yorkers with these problems, including by enacting requirements that insurers simplify their administrative rules and procedures. Hospitals are also committed to doing their part to lower costs for consumers, through a host of quality initiatives designed to reduce hospitalizations, emergency room use, and re-admissions. In testimony I gave to this Committee and the Hospitals Committee in October, we laid out the many major initiatives hospitals are engaged in to reduce costs for consumers and the Medicare and Medicaid programs.

- **People are rightly upset when insurers suddenly limit their networks of providers, cancel contracts with their trusted physicians and hospitals, and force them to switch providers.** The State can enact laws to help with these problems as well.

- **There are still New Yorkers who are not insured.** We now know a great deal more about who the uninsured are than we did a decade ago, thanks to our ACA implementation experience, data collected by the health insurance marketplace New York State of Health (NYSOH), and analysis done by the Urban Institute[5] on behalf of the State Department of Health. We know that about a third of the uninsured are already eligible for Medicaid but not enrolled; a third are eligible to purchase private individual coverage through NYSOH but find it unaffordable; and the remaining third are low-income undocumented immigrants who are not eligible for any form of subsidized coverage other than emergency Medicaid. GNYHA believes the State and City should develop and implement policies to expand access to coverage for each of these groups. Such strategies could include, but are not limited to:

---

[4] Goldenberg, Sally, "City Unions Say They Dread Impact of Single-Payer Proposal in Albany," Politico, November 29, 2018.

[5] https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf

- Administrative actions to streamline Medicaid enrollment and renewal
- Public education campaigns, as we have funded in the past, to get people enrolled in public programs for which they are eligible
- State-funded tax credits to supplement available Federal tax credits to make coverage more affordable for individuals with incomes between 200% and 400% of the Federal poverty level (FPL)
- Expansion of the Essential Plan or other targeted initiatives to wrap around emergency Medicaid for low-income undocumented immigrants

In addition, we have safety net hospitals, which are primarily dependent on public insurance payers—Medicare and Medicaid—that are in financially frail condition. We strongly advocate for better payment rates for them—including New York City Health + Hospitals—and will be working with the Governor and State Legislature in the coming year on enhanced payments for safety net hospitals through a variety of State programs, including Medicaid, the State's Indigent Care Pool, the Enhanced Safety Net program, and the Value-Based Purchasing-Quality Incentive Program.

Our Association is committed to the well-being of all New Yorkers and we stand willing to work with the Governor, the State Legislature, and the City Council to make sure all receive the quality health care they deserve.

I am happy to answer any questions you may have.

FOR THE RECORD

ANOTHER BUSINESS *for the* NEW YORK HEALTH ACT

"The pool of plans made available to small businesses has become extremely limited and the monthly premiums have steadily increased as well as the deductibles. The NYHA will make healthcare costs affordable and predictable and will allow us to spend more money investing in our staff and growing our business."

- Beacon's Closet -

BROOKLYN + MANHATTAN

beacon's closet

BUY • SELL • TRADE • VINTAGE + MODERN CLOTHING

Join the fight:

nyhcampaign.org/business

DISABLED IN ACTION OF METROPOLITAN NEW YORK
POST OFFICE BOX 30954, PORT AUTHORITY STATION
NEW YORK, NY 10011-0109 TEL/FAX 718-261-3737
www.disabledinaction.org

Testimony by Jean Ryan at NY Health Hearing in the City Council 12-6-18

I am Jean Ryan, President of Disabled In Action. We are a cross-disability civil rights organization founded in 1970. Long-term care and homecare is a right. We're confident that long-term care of all kinds will be included in the NY Health Act because not only is it a right, it is a necessity.

People are going without medical care because they cannot afford insurance or the co-pays from affordable insurance. People are going without long-term care because of not enough money to get care. People are having to quit jobs to take care of family members and then not have enough money to live on. Caregivers are losing their own health because they are unable to take care of themselves adequately, to get enough rest and medical care while they are taking care of their loved ones. People who are in need of full-time specialized care and who are dying and want to be home, are unable to stay home to die and get enough care because now through hospice they can only get 2 hours of care at home per day. Two hours! What about the other 22 hours?

When long-term care is a reality under the NY Health Act, people with disabilities will be able to live productive lives and be paid a decent salary in a productive job and not have to worry about making too much to get out of poverty as they do now under Medicaid. Caregivers will not have to worry about becoming ill or dead or impoverished while taking care of sick relatives. People with disabilities who need care will be get the care they need. This is our vision of what the NY York Health Act will mean to people with disabilities.

Thank you,

Jean Ryan, President of Disabled In Action of Metropolitan NY (DIA)
pansies007@gmail.com
917-658-0760

MEKONG

FOR THE RECORD

Testimony of Khamarin Nhann
Campaign Director, Mekong NYC

My name is Khamarin Nhann, I am the Campaign Director of Mekong NYC. Mekong aims to improve the quality of life of the Southeast Asian community in the Bronx and throughout New York City by achieving equity through community organizing and healing, promoting arts and culture and creating a safety net by improving access to essential social services. The Southeast Asian community in the Bronx primarily consists of Cambodian and Vietnamese.

I am here on behalf of the Southeast Asian community and all vulnerable communities that continue to be negatively impacted by not having adequate access to quality healthcare. We understand that marginalized communities across the nation have been facing social and economic disparities for generations. There are many barriers that are often force people from not receiving the care they desperately need. Our community are survivors, refugees, immigrants, un documents and citizens. Healthcare is a human right. We need to uplift the importance of what a universal single payer health plan would mean all for New Yorkers. We can be the leaders to providing such a system.

We need to build upon what the Affordable Care Act did and not try to undermine a system that has its flaws, but what can we do together to make it better for every New Yorker. It uplifted the importance of health care to nationwide conscious. We need leadership that will put the people needs above all else. How are we a nation with the most expensive healthcare system, yet we have so many people that either don't have access to healthcare, can't afford or don't have quality healthcare? We need to be honest and name what are the problems here, so we can make the effort in addressing a better solution that includes every New Yorker.

With everyone's community that shares their voices and narrative, it's important to witness people from all ethnic groups, religion, sexual preferences and walk of life. It is important that a universal single payer health plan would not only benefit the quality of lives for every community, but communities no longer must hide to seek the medical help them desperately need. We hear too many stories of community members that waited too long to seek the care they needed because of not being able to afford health care or too scared to seek help. Trying to navigate the healthcare system is an obstacle. Now imagine a community member that doesn't speak English, lives with mental illness and is trying to access the healthcare system. They would have to endure so much just to able to find out if they will get the medical treatment. Our healthcare system should be simple, clear and accessible for anyone who needs healthcare. Regardless of where they come from, their income, family circumstances and or health status.

No one should ever have to think twice about making life altering decisions based on their health and the cost of surviving. There are far too many burdens put on the shoulders on hard working families that seem just to never make it to a level playing field. Healthy people create, healthy families, healthy neighborhood and a healthy society. By addressing the healthcare system with a universal single payer health plan, we are acknowledging that the health of generations now and more to come is important for everyone who call New York there home.

I hope that this will continue the open dialogue between community- based organizations, other governmental and non-governmental and agencies. We understand the importance of a universal single health plan, and what that mean for all vulnerable communities. Through collective effort, we will be one step closer to making this a reality.

2471 University Ave| Bronx, NY 10468 | p: 347.918.9220. | e: mekong@mekongnyc.org | mekongnyc.org

I have been a New York City Substitute Teacher for several years, and have had little or no health care, and when I have been "covered" I have been denied of basic medicine. Most recently, my health insurance stopped covering an asthma inhaler I have taken for over 10 years on a daily basis. It is considered a long-term care inhaler, and it is the only thing that has kept me from being in the ER or extended hospital stays. When I tried to obtain my medicine, they informed me I could pay $300. There was no advance notice given, I was just denied this medicine. This shock was very bad, and worse was the underlying feeling that our system is so unkind to people, that it is as if someone's life is less important than the profit of pharmaceutical companies. Many people die of asthma. With the climate change that we have experienced, it has exacerbated problems with breathing. Many people I know have suffered terribly (who are under medically supervised treatment). I went sporadically for 6 months without it, each night being fearful of going to sleep when breathing problems worsen. It literally took this amount of time to research a new health insurance, find a new doctor I could go to, and a pharmacy who would fill the correct prescription (and not 1 of a dozen other "replacement" inhalers which are all supposed to be alike, but are actually much cheaper, less correct at successfully helping my lungs to breathe) were force upon me until I could finally get the one I needed at a reasonable price.

People should not have the additional stress of having to deal with personal and global world problems, and also have to worry so much about their everyday well-being!! Let's cut out the middle men those greedy, sleazy insurance companies whose salaries and annual bonuses and even firing bonuses worth millions and billions, could actually fund MEDICARE FOR ALL!! LET'S STOP THE PROFITING OFF OF THE LIVES OF PEOPLE!! Let's stop allowing people to die because of lack of or insufficient health care!! Americans deserve guaranteed health care which will allow people to concentrate on living their best lives!! And not have to worry about dying because they can't afford treatment for a serious illness or from a freak accident (which seems to be an increasingly growing problem). We need a system that is kind to everyone and helps people to live better lives, not potentially hazaardly shorten it! We need a system for everyone that is fair and affordable, and that system is #MedicareForAll. We need this NOW so we can be a happy, and healthy thriving nation once again, and like we've never been before!! Let's join the global economy, save billions of dollars, and put it back into who deserves it: THE AMERICAN PEOPLE!!!!

Thank you.

Andy von Salis
271 11th Street
Brooklyn, NY 11215
(constituent of Councilmember Brad Lander)
December 6, 2018

New York City Council – Hearing on Resolution 470 – in support of the Resolution:

Testimony of Andrew Mead **von Salis**, Brooklyn resident and attorney

I am a medical-malpractice lawyer of 30 years; I have extensive experience getting people not only due compensation for their medical injuries but also restorative treatment of them. Health insurance is an obstacle to each aspect of that challenge.

As a low-income solo professional now, I am a Medicaid and Medicare patient who has found both my Medicare and my Medicaid to have lapsed this year due to their miscommunication or error. Despite my doctorate-level degree and my professional experiences, I now struggle to remedy that.

Optional versus mandatory Medicare enrollment, premiums charged on Medicare coverage, primary versus secondary coverage, financial qualifications for enrollment, coverage exclusions, and other issues are complex enough to stymie my clients and me – and many Medicare or Medicaid staff too.

I have asked some physicians under oath during their depositions, or off the record during breaks, about my clients' health insurance. Ever since President Clinton delegated Hillary in 1989 to propose a federal single-payer program, these doctors almost always say such a program would have been better for them – and for their patients' health – than the for-profit health insurance industry is. They've spelled out reasons, and expressed their own frustration too.

My clients have told me unimaginable stories of just how private health insurance has hurt or killed them or a patient on whose behalf we're suing. Sometimes it's insurance obstacles, and not actual medical malpractice, that directly caused those disabilities and deaths. Then, I can only commiserate!

The anguish of losing a parent is multiplied when the child is an adult with a duty to figure out how to get their parent the medical treatment that would rescue their life or health. Too often, insurers' denials of needed treatment rest on its costs – the profit motive. I continually encounter rage, despair, and anguish as families hope and pray in vain. And when I do win compensation for the damage done, health insurers assert over-aggressive liens against it, frustrating justice.

New Yorkers truly need single-payer healthcare. Thank you.

/s/ Andrew Mead von Salis

I want to tell you a story about my friend Bill as he and I are very similar but separated by almost two decades. Bill Meier started working as a messenger around his 18th birthday, first in SF and then in NYC. When I met Bill I had just started working. He was a welcoming figure in the community and embraced all. As a frequently lonely person in NYC, his friendship was very welcome. As Bill aged he occasionally needed help from us. I was happy to offer him what I could but unfortunately it was not enough. One day Bill passed out from blood loss. He'd been carrying an untreated ulcer for years. We all knew something was wrong but we're not doctors! Our efforts to help him, in the form of couch surfs, home cooked meals, a bike to replace his when it got stolen, even fundraising a move to more hospitable southern california, were no substitute for the routine medical treatment an ulcer should receive. Bill didn't make it. He's not the only one of us to die or be seriously affected by deferring our treatment. As a messenger, it's similar to the other low wage jobs that make NYC run. There's often a murky corporate structure, so healthcare won't come from that. A culture of toughness and the fear of losing work precludes workers comp to most. There's the pressure to run around all day and then the overwhelming urge to relax or cut loose on your off hours, making it hard to research affordable options. There's a tax bias against bike work, so our vehicles (bikes) and fuel (lots and lots of food) are not taken into account when calculating work expenses, making many of us ineligible for medicare despite our grueling job and high living expenses.

I want a healthcare system that recognizes the value of a strong and healthy population and is accordingly publicly funded. I want a healthcare system that eases the confusion and burden of preventative care. I want a healthcare system that doesn't enrich corporations. I want a NY Health Act to be a universal single payer and give medicare for all.

Austin Horse
New York Bike Messenger Association

Honorable Council Members:

My name is Jane Willis. Thank you for this Public Hearing.

The New York Health Act is under siege by billionaire lobbyists who want to protect an Industry that profits from our illness and injury.

For those of us giving Testimony today, our personal stories are our currency.

And we'll keep telling our stories until the New York Health Act is passed into law.

I self-pay into an ACA plan with robust monthly premiums – Premiums, we'll remember – the Supreme Court determined are TAXES.

I needed to get foot surgery. A bone spur on my right foot. It hurt to walk. The spur needed to be shaved down and corrected. A simple procedure.

Metro Plus sent me their list: two podiatrists.

The first doctor wasn't on staff at a hospital that took my plan. The Insurer rejected the second doctor because of a discrepancy with his tax ID number. Both doctors offered to submit Appeals, so they could treat me --- but both admitted most Appeals were time consuming, and were usually rejected by the Insurers. This was no longer about my foot. So far, I'd shelled out $160 in copays. And neither doctor could treat me.

As my farmer Dad would say Metro plus sold me a bum steer.

Then the second doctor – a Rockstar – did something the Insurer couldn't or wouldn't do – he matched my plan with a former student of his, and a hospital. The surgery was done. My foot's okay, although the uncovered expenses keep rolling in.

By design, Commercial Insurance is full of tricks and trap doors. Lots of out of pocket and hidden expenses, even after folks have paid their premiums, and co-pays, while eating their deductibles.

And why are doctors and patients doing all the administrative work?

By design, The New York Health Act allows doctors to treat patients, and not the needs of the Insurer. And, If I'm paying taxes for healthcare, I'd much rather pay into a system that's about helping people get better, not lining shareholder's pockets.

I urge you to support Resolution 470. Thank you.

Good afternoon, Councilmembers.

Many thanks for hosting this event. For those of you who don't know me, I am failed Congressional candidate Joshua Sauberman from Whitestone, Queens. I greatly appreciate the opportunity to have a two-minute, four-letter conversation about healthcare, and it's vital importance to the sustainability of our great City and State.

As a recent Congressional candidate, my bid fell far short of expectations not for lack of charisma or personality; both of which, admittedly, remain in short supply. Instead, it was for the recurrence of cancer, which requires a substantial financial commitment even with insurance. Despite now having health insurance, groundbreaking advancements such as immunotherapy are still not covered by most insurers. The fact that I stand before you now is but a mere testament to my rapidly depleting wealth.

But what about those who haven't the means or resources to survive? Do we tell their family and friends: "Sorry, Charlie, but your insurance will only cover FDA-approved treatments that may cause you greater harm than your actual disease?" Too often, I've seen family and friends go without treatment. Some have even set up GoFundMe accounts to cover the added expenses of our deregulated healthcare system, which is rife with bureaucratic largess and free bottle koozies.

Recently, my mum, who is a special-education teacher in Jamaica, was denied approval for an MRI of her knee by Evicore, a third-party provider of EmblemHealth. An employee at their outsourced call center in the Philippines, a nation with universal healthcare, determined that her physician needed to send detailed notes before they would authorize the scan even though her doctor got on the phone in the middle of seeing a patient to re-state the urgent nature of his request. It took four days and a call to the NYS Department of Financial Services before she would learn she had a torn meniscus, and another two weeks before they would operate.

I don't know how you feel about this, but I find these increasing obstacles to care wholly unacceptable in a developed nation like America.

During my recent run for Congress, I had identified and emphasized many cost reductions and tax-savings benefits that would keep more New Yorkers in their homes. In particular, a single-payer system would save families upwards of 25% on their property taxes and would allow municipalities to re-allocate savings towards critical public services.

As our roads and rails decay alongside our overburdened hospitals and schools, and at a time when both our Mayor and Governor are hell-bent on accommodating the whims of the monied few, shouldn't we send a message to Albany that we will not stand by idly as our loved ones die in the street?

I implore this City Council to pass Resolution 470 in support of the New York Health Act because no New Yorker can afford to wait another moment longer.

With regards,

Joshua Sauberman
Post Office Box 231010
New York, NY 10023-0017

My name is Ellen Polivy. I am a medical social worker in private practice helping disabled older adults navigate the health care system. I am also a licensed health insurance broker.
One year I took the training to sell Medicare Advantage plans to see what it was like. That was my first and last year. These for-profit companies skim off the well seniors with promise of health club benefits and leave traditional Medicare to pay for the higher need patients. Each year from October 15 to December 7 these companies compete to gather the largest market share of Medicare recipients. Medicare recipients can change their plans any number of times during that time. So companies try to woo them away from each other. musical chairs. On December 7, enrollment stops dead. You are locked in for a year. To Medicare's credit, the companies have rules so they can't be too aggressive in their marketing. I represented nine different companies out of the 38 plans available in NYC. I also sold Medicare drug plans. That's an insane amount of paper. I had a closet full of glossy brochures and applications. Imagine all that paper going out to thousands of brokers in counties all over New York State. Brokers are trained to choose the company that has the patient's doctors in network and that have the patient's drugs in their formularies. (But people aren't static and doctors and drugs change. People should not be limited to doctors and drugs from a list.) Sales people believe that they are providing a service. They work on commissions. Between $200 and $400 a sale. that money comes from our Medicare dollars. The efforts have worked. In NY State in 2017, one third of the Medicare recipients had Advantage plans. The waste of money is astounding. How these companies got a foot in the door of a perfectly good system is a disgrace.

As a social worker and private care manager for 40 years, without question, it has been far easier to deal with traditional Medicare and Medicaid (the closest we have to a single payer) than any of the for-profit companies. Medicare and Medicaid are transparent. There have clear, published rules and procedures with honest appeals system and lots of professionals watching and keeping the system fair.

Traditional Medicare is simple. You can see any provider who takes Medicare. I can arrange home doctors, therapist etc. for homebound patients. tests or treatment can happen quickly.

Contrast that to a private plan. I call it "crapified" health care. Unnecessary barriers to necessary treatment. Networks, long wait times, precertification, requests for more information, denials. Appeals. The reason is clear. Medical care is the company's liability. If they make it too easy, people might use it more. If they make it difficult for a high cost patient, next year that patient will choose a different company. Or maybe they will find a way to qualify for Medicaid or EPIC and be allowed out earlier.

The choice is clear. A single payer caring for everyone from cradle to grave must take the long view. Better and less costly health care for everyone. Private health care is a colossal waste of our money and a danger to our health. We need a single payer system now.

December 6, 2018

Jeff Mikkelson
222 W 15th St #2D
New York, NY 10011
(646) 483-3397

Testimony before the NYC Council Committee on Health
Public Hearing on Resolution 470
In support of the New York Health Act

Dear Council Members,

My name is Jeff Mikkelson. I have been a freelance photographer and small business owner in New York City for almost eighteen years. For the first several years of my career I had no health insurance because I could not afford it. During these years I did not see a doctor or dentist and went without treatment for issues that, for all I knew, could have proven life-threatening. I was lucky enough not to get seriously ill or injured during this time, but not having insurance was the source of constant anxiety, knowing that if at any point I needed serious medical treatment, I would either go without or I would go bankrupt. Eventually I was able to purchase a cheap insurance plan through the Freelancers Union, which was an improvement, but just a few years later when the Affordable Care Act was passed, those plans became obsolete, and I was forced to buy insurance on the individual marketplace at a much higher premium and with higher deductibles. I won't deny the ACA has done *some* good. My wife, for example, a freelance artist herself, gained insurance for the first time under the ACA—but as we discovered when we married three years ago, the ACA also contains a marriage penalty, and our combined income caused her premiums to skyrocket. My own health insurance premiums and deductibles rise every year, with constant, bewildering changes in coverage and network access. My current plan, with a monthly premium of $600 and a deductible of more than $7000 is set to rise 15% next year, and to top it all off I received a letter from my insurance company informing me that they are dropping coverage for my primary care provider starting next year. As a small business owner, I can tell you, this constant runaround is a burden and a distraction that saps creative and entrepreneurial energy, impacting freelancers like myself in material and immaterial ways that go far beyond the official figures. I believe our private health insurance system is unjust, inhumane and unnecessary. Passing the New York Health Act would lift an enormous weight from the shoulders of small businesses and allow millions of self-employed New Yorkers to live with greater dignity and without the anxiety of wondering whether they can afford what should be a basic human right. I urge you to pass Resolution 470 in support of the NY Health Act.

Thank you.

Sincerely,

David A. Lee
Testimony to the New York City Council Committee on Health on Resolution 470
6 December 2018

Mr. Chair, members of the New York City Council Committee on Health, and fellow organizers for the fight for health care justice, thank you for this opportunity to share my story with everyone today.

My name is David Lee. I was born in this city, and am a proud resident of Queens.

Earlier this year, as a Columbia University student, I suffered from severe depression. I remember feeling deeply isolated and helpless in the face of a damaging school culture. The wonder I felt from learning was extinguished. I stopped going to class. My condition was debilitating enough that even mundane tasks like getting up out of bed or eating seemed laborious.

I left school on medical leave. Columbia policy mandates that in order for students to return, they must receive treatment and procure a doctor's note proving so. But for me, affording mental health care is out of the question. My low-tier health insurance covers next to nothing, and the school health plans range from an outrageous $3,000 to $4,500 for one school year alone.

It is economic injustice that a university with a $10 billion endowment does not fully subsidize the health care of its students. But it is truly a moral disgrace that because I am not rich, I am hurt by a system that sees me as not deserving of quality care.

Because I cannot afford treatment, I will not be continuing my studies at school. I have lived my life without treatment for months. Until single-payer health care is realized in New York, this is my reality.

I urge this City Council to vote in the affirmative on Resolution 470 in support of the New York Health Act. But more importantly, I urge you to have the moral imagination to envision a society in which we put the sanctity of people's health over the cruel greed of corporate profits. I want you to say it with all of us: guaranteed health care is a human right. Thank you.

DANA OFFENBACH TESTIMONY

(danaoffenbach@yahoo.com 917.825.0204)

- A native New Yorker who has been working and paying taxes in this state and city since I was 14 years old
- small business owner who's business is too small to secure a heath care plan so I fall into the pool of over 4M freelancers in New York.
- I spend around seven figures annually in my beloved city through this small business that is too small to have great health insurance
- HOWEVER – I pay more taxes than some corporations in NYC.
- When I worked in a corporation I had the best healthcare plans – why as an independent contractor am I not afforded the same? We deserve the same great healthcare our elected officials get. Nothing less.

We're falling through the cracks.

Press Release statement:

I am a native New Yorker who owns her own small business that is too small to have a health insurance plan but pays more taxes than some major corporations. My company spends around seven figures a year in my beloved city and as a "freelancer" I can NO LONGER get a PPO or even a good health insurance plan. I can't even get close to the quality of health insurance my elected officials get. I am one of over four million freelancers in New York who are falling through the cracks.

Testimony regarding the City Council public hearing on Dec. 6, 2018 on the New York Health Act:
Submitted by Beverly Koster, LCSW, Entitlements Advocate

Good afternoon. I am an advocate assisting people in applying for Medicaid and home care services. I am findingit to be increasingly difficult to obtain live-in home care services for people who are in definite need of this level of care. I have been successful through the Immediate Need Program in getting approval for 24 hour live-in home care for my clients, but when they need to transition to managed long term care, that is where I have run into serious problems. I currently have a client who is 101 years old and who can now do absolutely nothing for herself, including getting out of a chair without the hands-on support of an aide and her walker. She had gotten live in care through the Immediate Need Program, and also from the subsequent managed long term care. However, due to the recent reshuffing of vendors losing their contract with an MLTC if they have an enrollment of less than 75 clients, in order not to lose her aides, we went with another MLTC that has a contract with the same vendor. The nurse approved only 9 hours and told her son and daughter-in-law, who live in an upstairs apartment in the same house, to get a baby monitor. Another client, 97 years old, who wobbles greatly the moment he stands up, is getting live-in home care, also through Immediate Need, but the MLTC nurse evaluating him said he qualifies for only 9 hours, even though, despite using pull-ups, he frequently wets the bed at night. The daughter of another client with dementia was told by the MLTC nurse to see if she could get some medication for her mother "to control her behavior." After I told the daughter that was reportable, the agency backed down big time and approved the necessary live-in care.

The MLTC nurses use a computer program to determine needed hours of care, but this program does not capture the total needs of a client. If someone needs help getting dressed in the morning, do they not need the same help getting undressed and into pajamas a night? Do they not need the same assistance with dinner meals as with breakfast and lunch meals? They also split hairs on definitions—for example, if a person is "forgetful" about taking their medications, they don't need an aide for this. A family member can call to tell them to take their medication; the person will hang up and do it. If the person is "confused" then they need an aide, because they will hang up the phone and do nothing. The Immediate Need is a far superior program, as it captures the needs of the client in a way that the MLTC's frequently do not do.

I am one person, but I speak to many vendor agencies, and I am hearing over and over how the MLTC's are reducing hours of care for their clients. I support whatever it takes to ensure that disabled people in need get the care at home that they deserve.

Thank you very much.

December 6, 2018

I am Marc H Lavietes MD, long time activist with Physicians for a National Health Program. Two comments:

1. I am here as a physician. As such I will make no financial profit with the implementation of a single payer program. No single payer supporter here - physicians, nurses, social workers, community activists - stands to profit financially from the introduction of a single payer plan. In fact some of my higher paid colleagues, subspecialty surgeons for examples, will lose money. For us? With a single payer system we will be able to deliver better care to more patients in a more user friendly health care system.

Re: detractors of single payer. Detractors, e.g., insurance and pharmaceutical industry representatives, in truth are here to protect our current convoluted health care delivery system, a "cash cow" for them. Their contention that single payer will be prohibitively expensive is absurd - all other industrialized countries provide better health care to all of their people, and at a lower cost.

My plea: please make certain that with each presentation, you consider both its content and its source - who is speaking?

2. Can a single payer system succeed at the State level? Our State has a glorious history of paving the way for comprehensive progressive legislation at the National level. We should proudly remember Al Smith, Assemblyman and later Governor one hundred years ago, whose advocacy for child labor laws, workplace safety and minimum wage law became State law that a decade later would serve as a template for the New Deal. We should do this again!

Marc H Lavietes MD
Board member,
Physicians for a National Health Program,
NY Metro Chapter

35 Mercer Street #4W
NY 10013

Alec Feuerbach
NYC Council Healing
12/6/2018

My name is Alec Feuerbach. I am a medical student and the current fellow for the NY-Metro Chapter of Physicians for a National Health Program. With them, I work with the rapidly growing contingent of medical students that support single payer. Now with nine chapters of Students for a National Health Program at medical and public health schools across the New York Metro area, we are seeing more and more students join the fight for single payer healthcare each year.

I believe the reason for this is simple: we are in medical school because we want to help people. Yet, as we get deeper into our training, we see that "helping people" is often not possible. Frequently, we have no choice but to present patients with an impossible dilemma: go without needed care, or go bankrupt trying to pay for it.

Now don't get me wrong, as a medical student, I know first hand the power of modern medicine. I remember a patient who came to the Emergency Room unresponsive and seizing, only to be healed and begging for discharge two days later because he wanted to take pictures of Central Park, in the snow, with his wife. So there's no doubt that in this city, we witness some of the most advanced medicine in the world. And yet, so often we must bear witness to the ways the structures governing our healthcare system prohibit the provision of even the most basic care.

Just last month, I walked out of the hospital at midnight, met by a man in a wheelchair, shivering in the cold. He needed a place to sleep. We stood right outside of the Emergency Room, but my first thought was about what an unaffordable hospital bill would do to any hope of a better future for this man. I don't want to practice in a system where this is the first thought that comes across my mind when I see someone in need. None of us do.

In New York, we don't have to have that system. With the New York Health Act, we could implement a system in which everyone can access the world's most advanced medicine; one in which nobody would have to go broke doing so. With the New York Health Act, we could enact a system in which we would be truly proud to train and practice; one in which we could focus on the reason we came to medical school in the first place: to help people.

I urge you to support the New York Health Act. Thank you.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM — NEW YORK METRO CHAPTER

Testimony of Oliver Fein, MD
Chair, Physicians for a National Health Program – New York Metro Chapter
Before the New York City Council Committee on Health
Hearing on the Resolution in Support of the New York Health Act
December 6, 2018

I am a practicing internist, a professor of clinical medicine and health care policy at Weill Cornell Medicine. I am here today representing the New York Metro chapter of Physicians for a National Health Program, of which I am Chair. Our organization represents 22,000 physicians nationwide, and hundreds in this city, who advocate for a universal, publicly-financed system of guaranteed health care for all.

We strongly support the New York Health Act. As physicians, we constantly see the devastating consequences for patients who have no health insurance. We also witness an epidemic of under-insurance. Saddled with unaffordable deductibles and co-payments, many patients with insurance -- like the uninsured -- are forced to delay seeking care, stop their medications, and show up at emergency rooms for basic care. The NY Health Act guarantees coverage for all the uninsured and eliminates deductibles and co-payments for the insured.

I want to address some misconceptions promoted by opponents of the NY Health Act:

First, that the Health Act is government-run health care. In reality, under this bill, you and your chosen health care providers will make the decisions about your health care. No more narrow networks, no more insurance denials of needed care. NY Health would just pay the bill.

Second, that the NY Health Act bill will quadruple your taxes. Yet studies show that over 90 percent of New Yorkers will actually pay *less* in New York Health taxes than they do now for premiums, deductibles, copays, and out-of-pocket costs for health care and prescription drugs.

Third, that the NY Health Act will cut payments to doctors and hospitals. Actually, there will be sufficient savings from cutting out administrative waste and negotiating lower drug prices so that most provider reimbursement rates can be raised.

In sum, the NY Health Act is feasible, long overdue, and would allow doctors to return to focusing on providing the best possible care for our patients, while finally guaranteeing healthcare as a human right for all New Yorkers.

Committee of Interns and Residents
SEIUHealthcare.

Testimony of Dr. Jessica Edwards
National President, Committee of Interns and Residents/SEIU
Before the New York City Council Committee on Health
Hearing on the Resolution in Support of the New York Health Act
December 6, 2018

FOR THE RECORD

My name is Dr. Jessica Edwards. I am a board certified family medicine physician. I completed my residency and fellowship training in the tristate area. I'm also National President of the Committee of Interns and Residents, affiliated with SEIU. We represent over 6,000 doctors-in-training at New York City hospitals, and over 15,000 physicians nationwide.

Our union, CIR, supports what the New York Health Act is attempting to accomplish in having a single-payer healthcare system because we've made a commitment to helping our patients heal. We also recognize that, in its current state, the New York Health Act does not sufficiently protect the healthcare gains that CIR and other union members across the state have made through decades of collective bargaining. We want to thank the bill's sponsors, Assemblymember Gottfried and Senator Rivera, for being willing to sit down with union leaders to devise even stronger language to ensure that union members don't lose any of our hard-fought gains.

Today, many of our patients rely on private health insurance with unaffordable premiums, deductibles and copays; others on underfunded public insurance; and still others—including undocumented immigrants—have no coverage at all. As a result, we witness a constant array of horror stories.

Access to healthcare is a human right. For over 60 years we've fought to ensure that our patients and colleagues have a voice on the policies that regulate how and who can get medical coverage. By guaranteeing care, the New York Health Act will prevent much needless suffering, not only by patients, but also by the physicians who treat them. Many of us feel helpless working in a system that so many of our patients can't afford or access. No one should have to choose between food and medicine, housing and healthcare or education and healthcare. Not in 2018 and not in the state of New York! Our oath to do no harm extends far beyond the exam room; it's our responsibility as physicians, community members and as patients ourselves to advocate for commonsense legislation that supports the wellbeing of us all. Healthcare can no longer be a privilege that's handed to just the few who can afford it; we all have a right to a healthy life.

So I urge the City Council to recommend that union protections be incorporated into the New York Health Act. Having a single payer healthcare system is a necessity so that all New Yorkers can have affordable and accessible healthcare.

520 Eighth Avenue, Suite 1200, New York, NY 10018
Phone: (212) 356-8100 Fax: (212) 356-8111 E-mail: info@cirseiu.org http://www.cirseiu.org

FOR THE RECORD

Good afternoon. My name is Constancia Dinky Romilly. I am an advanced practice nurse, co-founder of the Pain Management service at Bellevue Hospital Center, now retired.

First, I want to express my bewilderment at the very idea of the insurance construct applying to health care. Let's bring some common sense into the picture; Insurance is something one obtains in the eventuality, hopefully never experienced, of a catastrophic event occurring, such as an auto accident or fire in one's home.

Health care, to the contrary, is an expected fact of life. As residents of NY State, we should expect that our health care would be seen in the same light as other aspects of our daily lives. We cover these together through one kind of tax or another: schools, roads, police & fire protection, sanitation, as a few examples. Let's apply common sense to paying for health care.

As an advance practice nurse working in the public sector, I saw the best in the public payment systems - Medicare and Medicaid. For the most part we were able to provide our complex patients with the whole range of interventions our multidisciplinary team proposed after extensive investigation of the pain issues presented. In those cases where the patient was so-called "self-insured", or sometimes in Medicare Managed Care plans, I saw the worst face of the mis-named insurance system. Hours spent on the phone, often with insurance company clerks whose job it was to deny the prescribed care. More hours duplicating explanatory letters, imaging studies, patient history to "justify" to the nay-saying company employee. This is madness and the solution is at hand.

Please pass Resolution #470 in support of the NY Health Act, for all New Yorkers.

Thank you.

Constancia Dinky Romilly, RN, MS
39 E. 7th Street, Apt. 1
New York, NY 10003
cdromilly@gmail.com
917 991 5653

iHealth NYS

Testimony to New York City Council Health Committee
Oversight – New York Heath Act
Res 470-2018

FOR THE RECORD

December 6, 2018

Good afternoon Chair Levine and members of the Health Committee. My name is Matthew Lesieur and I am the Executive Director of iHealth New York State. iHealth, Inc. is a coalition of pioneering community-based organizations providing care management services that advocate for our members and the chronically ill Medicaid recipients they serve. iHealth providers reach New York's most marginalized residents who are faced with chronic illness such as HIV/AIDS, substance abuse, mental illness and other behavioral health challenges.

iHealth represents the premier care coordinating agencies that care for chronically ill New Yorkers. iHealth has emerged as an expert in the provision of care coordination services, we address the social determinate of health that impact the most vulnerable New Yorkers by identifying the problem, finding solutions and coordinating care with the appropriate healthcare provider.

We're here today to testify on the New York Health Act, and we support a single-payer system for all New Yorkers. However, in order for that system to achieve its full potential and ensure that everyone, especially those with more complex challenges, receives the medical care they need, the system must include robust support for health care coordination services. We are united in the belief that care coordination is the most effective model to reach the highest need individuals. Our services help reduce health care costs and help improve the lives of the sickest and neediest in the Medicaid system that cost the most.

Health homes have improved the quality of care significantly for many with chronic health challenges, with members in health homes experiencing a 8.4% improvement in their adherence for antipsychotics for those with schizophrenia, and health home members having a 11.1% reduction in readmission to a hospital within 30 days of discharge.

If New York State aims to make this single payer system a success and a model that is replicated throughout the country, there needs to be a thoughtful accompanying plan around care coordination for the highest needs individuals - this will make the system more efficient for it's patients and more cost effective for the state.

We would be happy to engage in a dialogue and work closely with the City and State to flesh out a way to incorporate care coordination into the upcoming plans to create a single payer healthcare system.

In the meantime, we ask the New York City Council to pass Res 470-2018 calling on the State Legislature and Governor to sign A. 4738/S.4840-A establish the NY Health program, a universal single payer health plan for all NYS residents. The Single Payer Healthcare bill has passed the Assembly consecutively for four years and we hope the Senate takes the same courageous steps as well as Governor Cuomo to provide New Yorkers with a high quality health care system.

Thank you for your time and I'd be happy to answer your questions.

Matthew Lesieur
Executive Director
iHealth
307 West 38th Street, 3rd Floor
New York, NY 10018
Mobile: (917) 545-2670
Office: (212) 367-1270
matthew@iheatlhnys.org

Testimony before the New York City Council

by

Henry Moss, PhD
Board Member, Physicians for a National Health Program, NYC Metro Chapter

December 6, 2018

Conservative anti-government ideologues from the Manhattan Institute and the Empire Center for Public Policy are spreading myths about the New York Health Act. They are contradicted by the facts. One set of myths concerns the role of government in health care.

Myth: The government cannot control health care costs.
Fact: Costs in the current market-based system have risen by 50% since 2000 and are still out of control.[1] Premiums have risen by 19% over the past five years.[2] Countries with single-payer or heavily-regulated universal systems spend half of what we do, on average, with better health outcomes.[3] These countries, and government single-payer programs like Medicaid and the VA also use the negotiating leverage of government to get much lower prices for drugs and medical devices. Heavy lobbying by the pharmaceutical and medical device industries has prevented Medicare from also negotiating for lower rates.

Myth: The government cannot run an efficient health care system.
Fact: The Medicare Trustees reported that, in 2015, Medicare had administrative overhead of under 2% of total expenditures, despite dealing with patients with much greater and more complicated medical needs. The Congressional Budget Office, on the other hand, reported 13% for commercial insurers, which, of course, gets passed along in premiums.[4] This includes the cost of excessive executive compensation, corporate profits, marketing expense, and the thousands of insurance claims processors needed to answer calls from physicians seeking approval to provide medical care, and for other wasteful practices aimed at reinforcing the bottom line. These practices include excessive pre-authorization requirements and excessive claims denial and appeals processing where an astounding 75-80% of appeals are successful.[5]

And there are the additional thousand of billing and insurance clerks working for hospitals, physicians, and other providers who spend their time interacting with hundreds of different insurers with thousands of different plans. Each plan has different procedures, formularies, and payment scales which are constantly changing, and where further complications arise when a company changes insurer or a patient switches employer. Providers also have to chase down patients to collect cash balances and manage a cumbersome physician credentialing process that differs from plan to plan and from hospital to hospital.

Physicians in private practice report spending upwards of 1/6 of their time interacting with commercial insurers for pre-authorization or a claim denial appeal.[6] That is hardly efficient.

The New York Health Act would have little or no pre-authorization requirements, only one drug formulary, and a single set of pricing guidelines. There would be one-click claims processing through synched computer systems and a central database for credentialing. There would be no collections needed because there would be no cost-sharing. And as the system moved away from fee-for-service payments, and toward global budgeting for institutions, even further efficiencies would be available through annualized bulk payments. Physicians would be freed from wasteful administrative work and could spend more time with patients, see more patients, or take time off to prevent the burnout they say has been accelerated by increased administrative burden.

Myth: Government programs are overly bureaucratic and result in poor customer service.
Fact: The single-payer Traditional Medicare program is hugely popular. According to the Kaiser Family Foundation, 88% of those over 65 have a favorable opinion, including 67% of older Republicans. 69% of those under 65 also have such an opinion.[7] There are similar levels of satisfaction for single-payer systems in other countries despite nagging problems generated by misguided austerity policies.[8]

Commercial insurance programs lag behind government programs in patient satisfaction and the media is dominated by horror stories of patients suffering or dying because of insurance company policies driven by the corporate bottom line.

Myth: The New York Health Act would mean government control of health care delivery, i.e., socialized medicine.
Fact: The New York Health Act establishes a public insurance system and will make payments for care. It will not direct the delivery of care. Private hospitals and physicians will continue as independent operators under the New York Health Act and be in complete control of health care delivery. They will negotiate fair and reasonable payment from New York State in exchange for providing the necessary quantity and quality of care needed by New Yorkers.

And there will be no restricted networks. Patients can choose whichever provider they wish, and while all residents will be required to choose a care coordinator, typically a primary care physician, the coordinator will not have a "gatekeeper" function.

Market-based approaches to health care have failed us. Only the government has the leverage to get costs under control, serve the interest of its constituent communities, and meet its constitutional obligation to safeguard the health and welfare of all.

Notes

1. CMS data as reported in Sahadi, J. (Jan. 30, 2018) "Warren Buffett is right: Health care costs are swallowing the economy". *CNN Business* https://money.cnn.com/2018/01/30/news/economy/health-care-costs-eating-the-economy/index.html
2. Ibid.
3. Sawyer B. & Cox, C. (2018). "How does health spending in the U.S. compare to other countries?" *Peterson-Kaiser Health System Tracking*. Published jointly by the Peterson Center on Healthcare and the Kaiser Family Foundation. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-relative-size-wealth-u-s-spends-disproportionate-amount-health
4. Sources available in Scholars Strategy Network. (February 2017). "America's public Medicare program costs less and is more efficient than private health insurance". Cambridge, MA. https://scholars.org/brief/americas-public-medicare-program-costs-less-and-more-efficient-private-health-insurance
5. Blanchfield, B. et al. (2010). Saving billions of dollars – and physicians' time – by streamlining billing practices. *Health Affairs*, 29:6. https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0075
6. Woolhandler, S. & Himmelstein, D. (2014). "Administrative work consumes one-sixth of U.S. physicians' working hours and lowers their career satisfaction". *International Journal of Health Services*. 44(4), 635-642. https://www.ncbi.nlm.nih.gov/pubmed/25626223
7. Brodie, M., Hamel, E. & Norton, M. (2015). "Medicare as reflected in public opinion". *Generations*, published by the American Society for Aging and available on line at https://www.asaging.org/blog/medicare-reflected-public-opinion
8. Hero, J., Blendon, R., Zaslavsky, A. & Campbell, A. (2016). "Understanding what makes Americans dissatisfied with their health care system: An international comparison". *Health Affairs*. Vol. 35, No. 3. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0978

Contact information: hmoss011@gmail.com

To: Speaker Corey Johnson and Members of the New York City Council
From: Judy Sheridan-González, RN, President, New York State Nurses Association
Date: Thursday, December 6th, 2018
Re: Official testimony in support of Resolution 470 in favor of the New York Health Act

My name is Judy Sheridan-González. I've been an emergency room nurse for 34 years. I live and work in the Bronx, the county with the worst health statistics in NY. I'm also President of the New York state Nurses Association, representing 42,000 nurses across the state.

Nurses deal with the nitty gritty of health care, a roller coaster system that can transplant a liver, a heart, lungs--but can't prevent cases of cirrhosis, heart attacks, strokes, and cancer.

Be aware of these invisible cost factors, that we witness in our practice, knowing that flaws in the system directly contribute to patients' inability to stay healthy.

Lack of access to affordable, quality care results in preventable traumas and complications. The system is *designed* to pay homage to insurance companies, not patients.

We take an oath to "do no harm." Our system *causes* harm—and costs far more.

Patients with predisposing factors to organ damage forego appointments due to costs, copays & changes in providers. They don't fill prescriptions or cut meds in half.

I remember a gentleman who'd come to the ER to check his blood pressure periodically. One day, he arrived, with an ischemic stroke & a BP of 240/138. He stopped taking expensive cholesterol meds, missed appointments due to insurance changes; & couldn't renew his BP meds.

Hospitalized for months after his stroke, he regained consciousness but couldn't speak, eat or walk, eventually succumbing to complications. He died at the age of 48.

His two weeks in the ICU cost $140,000. A month of his BP meds cost $14(amlodipine) and $11 (HCTZ) respectively. His cholesterol drug cost $43 (simvastatin).

NYSNA's a union of caregivers; we also negotiate contracts for 42,000 nurses. While members cherish our health benefits, this consumes a huge chunk of financial packages. We're thrilled that the NY Health Act, once finalized, will provide superior benefits to those we currently enjoy—with *no* out of pocket costs. Even with a modest payroll tax, net costs will be reduced dramatically.

We know some unions fear the bill—it's an unknown—"better the devil we know," the saying goes. We're convinced that once details are ironed out to ensure no loss of current benefit, our sibling unions will embrace NY Health as much as we do.

In an atmosphere of vitriolic anti-union rhetoric, how inspiring that our NY unions, our committed elected leaders and community partners, will humbly usher in a universal health plan that embraces all of society: members, non-members, young and old, in the spirit of the birth of the labor movement whose motto was "an injury to one is an injury to all." A victory to one is a victory to all. Let's embrace victory. Thank you.

Testimony on Council Resolution 470
December 6, 2018

James Perlstein for the Social Safety Net Working Group
Professional Staff Congress/CUNY, AFT Local 2334

My name is James Perlstein. I am retired after 43 years of teaching at the City University of New York.

I speak for the Social Safety Net Working Group of the Professional Staff Congress, the union representing the faculty and professional staff at CUNY.

Our union believes that health care is a human right and a public responsibility. PSC has endorsed the principle of single-payer health care for all Americans. The New York Health Act, A.4738 and S.4840 (Gottfried-Rivera), is a constructive initiative pointing in the direction of universal, comprehensive and affordable care for New York State residents.

The New York Health Act is a work in progress. The PSC will continue to work with others to ensure that the high-quality benefits and protections already achieved by labor unions are not undermined and that the sacrifices unionized workers have made in salary to ensure good health benefits are recognized. The PSC will remain engaged with the bill's sponsors, our sister unions, and community partners to secure enactment of a law that serves the interests of all New Yorkers.

We view today's hearings and the resolution before the Council as a step in that direction and a valuable part of creating broader public awareness about the benefits of a single-payer system to provide high-quality, cost-effective health care to all New Yorkers.

Thank you.

12/6/18

TO: NYC COUNCIL, COMMITTEE ON HEALTH
FROM: Jim Bracchitta, CEBS
RE: Testimony in support of Council Resolution 0470 and the NY Health Act.

Thank you very much for the opportunity to submit testimony in support of Council Resolution 0470 and the NY Health Act. This written testimony will act as an extension and addendum to the remarks I made before the Committee on Thursday, December 6, 2018.

My name is Jim Bracchitta. I'm an actor by trade, and for the last 12 years I've served as a trustee on both the Screen Actors Guild Pension Plan and the SAG_AFTRA Health Plan. I also hold the designation of Certified Employee Benefit Specialist from the Wharton School and the International Foundation of Employee Benefit Plans. Let me say clearly, though, that the opinions I express here are my own -- not those of the Plans I serve on, or the unions that I belong to.

There's a retirement crisis looming in this country: an aging population, longer life expectancies, threats to gut an already frail social safety net, and perilously inadequate savings rates. In September, 2018 the National Institute for Retirement Security published a study which found, in part, that the *median* retirement account balance of all American workers is zero.

Zero.

Let that sink in. Half of all American workers have less than zero dollars in retirement savings.[1]

That's primarily because most American workers don't have an employer-based retirement plan at all. But the data shows that even those *with* a retirement plan are in serious trouble: Out of the 235 multi-employer pension plans in New York state, 60 — or just over 25% — are in either "critical" or "critical or declining" status. In the parlance of the Department of Labor, they're considered "in the RED ZONE," which basically means they don't currently have enough money to pay their outstanding pension obligations. And if nothing changes, they won't.

A short primer: Multi-employer pensions, which are primarily defined benefit (i.e., "traditional") pension plans, provide retirement benefits for 1.8 million New Yorkers, and tens of millions of workers across the US. They exist mostly in industries like construction, trucking and entertainment, where workers are subject to seasonal or occasional employment, and where they work for — as the name indicates — multiple employers. Although often called "union" plans because they're created through collective bargaining, this is a bit of a misnomer. These plans are administered by trustees representing *both* labor and management, and the future of *both* workers and the companies they work for are on the hook if they fail.

So what's all this got to do with single-payer health care and the NY Health Act?

It turns out that an overwhelming number of multi-employer pension plans in New York State have accompanying health and/or welfare plans. In fact, of the 1.8 million people in New York covered by multi-employer pensions, roughly a million of them are also covered by a sister health plan. And while not a perfect one-to-one ratio,

---

1 https://www.nirsonline.org/2018/09/new-report-finds-nations-retirement-crisis-persists-despite-economic-recovery/

these numbers indicate that the majority of workers who have contributions made on their behalf to a pension plan, are also receiving contributions into a health plan. Health and pension plans like these have a symbiotic relationship: similar sources of funding, corresponding workforces, and congruent governing bodies.[2]

A single-payer health system in New York would free these plans from the obligation to provide health insurance. And once that obligation is lifted, the money accumulated in these health plans can be transferred to an associated pension plan, shoring up funding levels and boosting retirement security. In other words, *an unexpected but welcome benefit of single-payer health in New York State could be a dramatic strengthening of retirement benefits for New York workers.*

The mechanics of transferring funds from one (health) plan to another (pension) plan would most likely have to be addressed in collective bargaining. But it seems clear that both employers and employees would have little reason to resist such a transfer, since both would have a stake in bolstering pension funding levels — not to mention a fiduciary duty to do the right thing for pensioners.

An issue for organized labor seems to be the fact that health benefits are one of the things that drive and define union membership. Unions are justifiably proud of providing quality health benefits for their members. The ties that bind workers to unions are wages and benefits, and unions are reluctant — especially in the face of strong anti-union headwinds — to relinquish anything that workers see as an added value. But it's clear that if workers' pensions go down the drain, the value of union membership would be irreparably shattered anyway. By supporting the NY Health Act, unions would be more likely to achieve the dual goals of comprehensive health care and a secure retirement.

---

[2] https://www.ifebp.org/store/Pages/horizon-retirement-report.aspx

The unsustainable costs and lack of access to quality care is enough of a reason to support the single-payer system envisioned by the NY Health Act. Now there's another: Single-payer can provide real and immediate relief to the crisis of underfunded multi-employer pensions. It may not solve the entirety of the retirement crisis, but it's way better than settling for zero.

Jim Bracchitta, CEBS is a labor trustee on the Screen Actors Guild Pension Plan and the SAG-AFTRA Health Plan, and holds the designation of Certified Employee Benefit Specialist (CEBS) from the International Foundation of Employee Benefit Plans and the Wharton School. For more than 25 years, he has been a professional actor on Broadway, off-Bway, on television, in films and in thousands of television and radio commercials. This past year, his television appearances included BLUE BLOODS, THE BLACKLIST, ORANGE IS THE NEW BLACK, DIVORCE (HBO) and SHOW ME A HERO (HBO); and on Broadway, he was in SIX DEGREES OF SEPARATION (with Alison Janey). He is a graduate of New York University, and a co-founder of The Cape Cod Theatre Project, a non-profit theatre company that develops new American plays in Woods Hole, MA. Jim is also a trustee of The Motion Picture Player Welfare Fund (an entertainment-industry charity), and a founding trustee of the NJ Boys State Foundation.

Additional info:

https://www.imdb.com/name/nm0102666/?ref_=fn_al_%20m_1)

Webinar: *Using Behavioral Tools to Drive Better Decision Making* (9/18/17)
See: https:// www.ifebp.org/education/webcasts/Pages/webcast17T23.aspx

Interview: *Insights from Industry Leaders* (hosted on LinkedIn by Benz Communications), see
https://www.linkedin.com/pulse/interview-jim-bracchitta-labor-trustee-screen-actors-guild- benz?trk=mp-reader-card

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/2018

(PLEASE PRINT)

Name: Mon Yuck Yu

Address: 1620 East 14 Street, Brooklyn, NY 11229

I represent: Academy of Medical & Public Health Services

Address: 5306 Third Avenue 2nd Fl Brooklyn NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rachel Feinstein

Address: [illegible]

I represent: NYPAN / Jobs to Careers

Address: _____

☆ Please give 2 min to Jean Fox and 2 min to Beacon's Closet (Lead by Jean Fox)

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jean Fox (on my own behalf) ☆

Address: _____

I represent: myself

Address: _____

Please complete this card and return to the Sergeant-at-Arms

☆ Beacon's Closet could not send a rep, so their testimony will be read by Jean Fox

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jean Fox on behalf of Beacon's Closet ☆

Address: _____

I represent: Beacon's ~~Not~~ Closet

Address: _____

(10)

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/2018

(PLEASE PRINT)

Name: CHARMAINE Ruddock

Address: 2006 MADISON AVENUE NY

I represent: BRONX HEALTH REACH / Institute for Family Health

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: December 2018

(PLEASE PRINT)

Name: Kim Behrens

Address: 145 THOMPSON ST #18

I represent: NYSNA

Address: 145 THOMPSON ST. #8

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Judy Sheridan-Gonzalez

Address: _____

I represent: New York State Nurses Association (President)

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 12/6/2018

(PLEASE PRINT)

Name: Naomi Zewde

Address: 160 W 91st St Apt E New York, NY 10024

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☐ in favor ☑ in opposition

Date: 12/06/2018

(PLEASE PRINT)

Name: Joseph Pidoriano

Address: 101 ST Stephens Pl., Staten Island, 314

I represent: myseA

Address: " "

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rhiannon Ross

Address: 58-38 Catalpa Ave Apt 1 Ridgewood, NY 11385

I represent: Myself

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: MORGAN MOORE

Address: 154 MACON ST. APT 1 BROOKLYN NY 11216

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: MAX HADLER

Address: _____

I represent: NEW YORK IMMIGRATION COALITION

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Sami Disu

Address: 214 E Mosholu Pkwy Bronx

I represent: my self

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 470 Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: GUY EDWARD

Address: 333 47TH ST BROOKLYN NY 11215

I represent: LEAGUE OF INDEPENDENT THEATER

Address: BROOKLYN

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 470 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Austin Horse

Address: 99 S 6th ST. BROOKLYN

I represent: New York Bike Messenger Association

Address: BROOKLYN

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 12-6-18

(PLEASE PRINT)

Name: MARC LAVIETES

Address: 35 Mercer St #4W NY 10013

I represent: PNHP

Address: ~~35 M~~ 133 W 33rd

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Bobbie Sackman

Address: _____

I represent: JFREJ/Caring Majority

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Henry Moss

Address: 5601 Riverdale Avenue, Bronx

I represent: Physicians for a National Health Program, NYC Chapter

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Sharon Kahn
Address: 1619 3rd Av, NYC 10128
I represent: NYC Psych
Address: same as above

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☑ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Kayla Lawrence
Address: 782 Pelham Pkwy S Apt F Bronx NY
I represent: NY Caring Majority NDWA, 1199SEIU
Address: Bronx NY 10462

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

in favor of NYHA

Date: 11/6/18

(PLEASE PRINT)

Name: Mimi McDermott
Address: 519 W 121 St, NYC 10027
I represent: ______
Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 470 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Barbara Estrin

Address: 3616 Henry Hudson Pkwy

I represent: NW Bronx Indivisible

Address: Bronx, NY.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Rich Hallman

Address: 377 Rector Place #11280

I represent: Self

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~NYHA~~ Res. No. 470

☑ in favor ☐ in opposition

Date: Dec 6, 2018

(PLEASE PRINT)

Name: Jane Willis

Address: 570 10th St. Brooklyn

I represent: NYHA

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12-6-18

(PLEASE PRINT)

Name: Jeff Mikkelson

Address: 222 W 15th St #2D

I represent: Small business owners

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/2018

(PLEASE PRINT)

Name: Joshua Clemon

Address: 92 Saint Nicholas Avenue

I represent: Harlem / Young Democrats

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 470 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jean Ryan

Address: pansie007@gmail.com

I represent: Disabled in Action

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Elana Lancaster

Address: 226 Eckford St. Brooklyn, NY

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Carol Clauss

Address: 201 Clinton Ave 1SF Brooklyn

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~470~~ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Ellen Polivy

Address: 531 Main St. #1019

I represent: Geriatric Care Managers

Address: 531 Main St, N.Y. NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 6-DEC-2018

(PLEASE PRINT)

Name: JOSHUA SAUBERMAN

Address: PO BOX 231010, NEW YORK, NY 10023-0017

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: Dec 6

(PLEASE PRINT)

Name: Anthony Feliho

Address: _____

I represent: CPHS and APICHA and NY Health Campaign

Address: 110 Wall street

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 476

☐ in favor ☐ in opposition

Date: 12.06.18

(PLEASE PRINT)

Name: HEIDI SIEGFRIED

Address: 841 BROADWAY

I represent: CENTER FOR INDEPENDENCE OF THE DISABLED

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Diego Quinones

Address: _____

I represent: Working Cyclists

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Colette Swietnicki

Address: 351 W 24th St Apt 9H

I represent: myself NY

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card 1

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: TOVA OVITS

Address: 1114 E 32 ST Bklyn 11210

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Alessandra Biaggi

Address: 1039 Peace St Bellmore NY 11803

I represent: (senator-elect)

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☐ in favor ☐ in opposition

Date: 12/06/18

(PLEASE PRINT)

Name: JAMES PERLSTEIN

Address: 330 12th St B'KLYN 11215

I represent: PSC/CUNY AFT #2334

Address: 61 B'WAY 10006

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 147

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Andrew Mead VON SALIS

Address: 271 11th St Brooklyn NY 11215

I represent: [self]

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 12/6/2018

(PLEASE PRINT)

Name: David Rich

Address: _____

I represent: Greater New York Hospital Association

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 12-6-2018

(PLEASE PRINT)

Name: Olanike Oyeyemi / NASW-NYC

Address: _____

I represent: National Assoc. of Social Workers-NYC

Address: 50 Broadway St 1001 NYC 10004

CACF
APA
Panel

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☐ in favor ☐ in opposition

Date: 12.6.18

(PLEASE PRINT)

Name: Carlyn Cowen

Address: _____

I represent: Asian Chinese American Planning Council

Address: _____

Please complete this card and return to the Sergeant-at-Arms

CACF
APA
Panel

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 12.06.2018

(PLEASE PRINT)

Name: Rachel Aicher

Address:

I represent: Arab American Family Support Center of NY

Address:

CACF
APA
Panel

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 12.06.2018

(PLEASE PRINT)

Name: Khamarin Nhann

Address:

I represent: Mekong

Address:

CACF
APA
Panel

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 11.2.06.2018

(PLEASE PRINT)

Name: Tasfia Rahman

Address:

I represent: CACF

Address:

Please complete this card and return to the Sergeant-at-Arms

CACF
APA
Panel

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 12.6.2018

(PLEASE PRINT)

Name: & SELVIA STKDER

Address: _____

I represent: India Home

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 0470

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: JIM BRACCHITTA

Address: 160 CABRINI BLVD #81 NYC, NY

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 12-6-2018

(PLEASE PRINT)

Name: JAMES MANSFIELD

Address: 305 W 28

I represent: MYSELF

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/06/2018

(PLEASE PRINT)

Name: Yleana Roman

Address:

I represent: New York Lawyers for the Public Interest

Address: 151 W 30st St, 11th Flr, NY, NY 10001

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~470~~ Res. No. 470

☐ in favor ☐ in opposition

Date: DEC 6 2018

(PLEASE PRINT)

Name: DAVID GURIN

Address: 500 4TH AVE, BROOKLYN 11215

I represent: SELF

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Hon. Richard Gottfried

Address: 250 B'way

I represent:

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~470~~ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: LEONARD RODBERG

Address: 310 W 86TH ST. #6B, NYC 10024

I represent: SELF

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Matthew Lesieur / iHealth

Address: 307 West 38 St NY 10018

I represent: iHealth

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~470~~ Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Priscilla T Bassett

Address: 45 Park Terrace West 10030

I represent: Statewide Senior Action Council

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Bob Ledew

Address: _____

I represent: Physicians for a National Health Prg.

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: MARVA WADE RN

Address: 31 W 33rd St

I represent: NYSNA

Address: 31 W 33rd St

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Alec Feuerbach

Address: 50 E 98 St 8A-4

I represent: Phys. for a National Health Prg

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: JAMES RYAN

Address: 40 HARRISON St #17H NYC 10013

I represent: INSIDER CULTURAL TOURS

Address: SAME

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/5/2018

(PLEASE PRINT)

Name: Dr. Elizabeth Kolod

Address: 305 E. 161 st St Bronx, NY

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: KOH HSU, YULING

Address: 144A NEWEL ST #3 BROOKLYN

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Rachel Bernstein

Address: 45 Columbia St.

I represent: For Medicare For All

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: DANA OFFENBACH

Address: 567 FORT WASHINGTON AVE

I represent: FREELANCERS

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: KimBerleigh Smith

Address: 356 West 18

I represent: Callen-Lorde

Address: 356 West 18th Street 10011

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/2018

(PLEASE PRINT)

Name: CHARMAINE RUDDOCK

Address: 2006 MADISON Avenue

I represent: Bronx Health REACH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: WINN REKIYASAMY

Address: 40 BROAD ST

I represent: FPWA

Address: "

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Alan L. Bounville

Address: 580 Brooklyn Ave, Apt. 2, Brooklyn, NY 11203

I represent: Myself.

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Beverly Koster

Address: 310 West 56th St, New York NY 10019

I represent: Independent Advocate for long term care services

Address: —Same

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~477~~ Res. No. 470

☒ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: CONSTANCIA ROMILLY

Address: 39 E 7 ST

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 470

☑ in favor ☐ in opposition

Date: 6 December 2018

(PLEASE PRINT)

Name: David A. Lee

Address: 94-14 41st Rd., Elmhurst, NY 11373

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 12/6/18

(PLEASE PRINT)

Name: Lisa Melilli

Address: 5420 15th Ave Brooklyn NY 11219

I represent: Myself, citizen

Address: _____

Please complete this card and return to the Sergeant-at-Arms